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ABSTRACT

The effectiveness of undergraduate education majors as play therapists was investigated by comparing measures of therapeutic outcome for 48 emotionally disturbed boys assigned to three treatment conditions and a no treatment control condition. Each treatment condition consisted of 12 play interviews conducted by experienced therapists, students with eight sessions of training in nondirective play therapy (experimental condition), and students with training in being friendly (placebo condition). Parent evaluations indicated that positive changes were greatest for children in the experimental group, next for those in the placebo groups, and least for those in the control group. The hypothesized superiority of the experienced therapists was not confirmed. This was thought to be due to lack of strict adherence to the techniques of nondirective play therapy. Performance ratings for the final interview indicated that the experienced therapists consistently scored significantly higher than the student therapists regardless of condition and that the scores for the experimental and placebo groups did not differ significantly from each other. In contrast, analyses for the process variables consistently indicated that the scores for the experimental group were significantly different from those of the placebo group. (Author/GW)

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Chicago, Illinois

September, 1970

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Summary

The manpower shortage in mental health has created a widespread interest in the possibility that various types of nonprofessional workers or lay personnel may help to solve this problem. During the past decade a number of studies has provided encouragement for the idea that these nontraditional workers with brief training (or even with no training) can work effectively with patients. However, a review of the relevant research suggested that the most basic question, the effectiveness of the lay workers in psychotherapeutic roles, has not been answered. In addition, it is not clear whether training in psychotherapeutic techniques is an important variable in the success of the lay workers and, if it is, the extent to which adequate performance of the therapist role can be attained through brief training.

The present study, in focusing on these questions, was also concerned with the possibility of using undergraduate majors in education as play therapists for emotionally disturbed children. The interest in using future teachers as play therapists was motivated by the possibility that this group represents a valuable resource which may contribute to the mental health of children in two ways: (1) through promoting mental health in the classroom and (2) by creating interest in and background for working in special programs for emotionally disturbed or handicapped children.

The effectiveness of the education majors in working with clients was investigated by comparing measures of therapeutic outcome for 48 emotionally disturbed boys assigned to three treatment conditions and a no-treatment control condition. Each treatment condition consisted of 12 play interviews conducted by: (1) experienced therapists, (2) students with eight sessions of training in nondirective play therapy (experimental condition), and (3) students with training in being friendly (placebo condition). Outcome was evaluated on the basis of pre- and posttherapy measures obtained from the children's mothers, fathers, and teachers (Semantic Differential and Target Complaints) and from the children themselves (Incomplete Sentences). The hypothesis that evidence of positive outcomes for the four groups of clients ranged from most to least for children in the experienced therapist, experimental, placebo, and control conditions was partially supported. That is, the measures obtained from the parents provided several indications that positive changes were greatest for children in the experimental group, next for those in the placebo group, and least for those in the control group. The comparable measures of outcome for the experienced therapists did not confirm their hypothesized superiority, i.e., evidence of change was either comparable to that obtained for children in the experimental condition (Target Complaints) or failed to indicate that the children had improved (Semantic Differential). None of the analyses of the outcome measures obtained from the children or their teachers was significant. The unanticipated findings for the experienced therapists were discussed in terms of the fact that these therapists did not adhere to the techniques of nondirective play therapy.

In considering the findings relevant to outcome, it was concluded that the evidence provided some support for the effectiveness of the experimental group (students with brief training in nondirective play therapy). The evidence also suggested that training was important in that the children in the experimental group consistently showed more evidence of improvement than those in the placebo group ("training" in being friendly).

The ratings of therapists' performance during the final interview and process ratings of therapists' verbal behavior for the first, fourth, eighth, and twelfth play interviews provided the basis for evaluating the effects of brief training in nondirective play therapy. The ratings of performance for the final interview indicated that the experienced therapists consistently scored significantly higher than the student therapists regardless of condition and that the scores for the experimental and placebo groups did not differ significantly from each other. While these ratings indicated that brief training in the techniques of nondirective play therapy did not differentiate the student groups as anticipated, it is possible that the rater was not evaluating performance in terms of variables considered important in the nondirective approach. That is, the rater may have assigned higher scores to the therapists who acted in more dynamic ways (a factor noted previously with respect to the performance of the experienced therapists). In contrast, the analyses for the process variables consistently indicated that the scores for the experimental group were significantly different from those for the placebo group. All obtained differences supported the hypothesized superiority of the experimental group in employing approaches appropriate to nondirective play therapy. These differences further indicated that the experimental group showed greater conformity to the nondirective role than their more experienced counterparts. The fact that the experienced therapists engaged in significantly more instances of Seeking Personal Information than the two student groups confirmed the idea stated previously that the therapists in this group tended to work very intensively with their patients in trying to elicit information relevant to the children's problems.

The effect of the training programs and play-interview experience for the students was investigated through two pretraining and posttherapy measures (Minnesota Teacher Attitude Inventory and Michigan Picture Test). While the differences between the three student groups on the posttest scores for Michigan Pictures were not significant, the scores for the Minnesota Teacher Attitude Inventory indicated a significant improvement in the attitudes of the experimental group toward children in contrast to the other two groups.

The discussion included consideration of possible applications of the present findings in terms of the use of college students with brief training in nondirective play therapy in work with children. In addition, several areas in which further research is needed to clarify the roles of nonprofessionals in mental health work were suggested.

Introduction

Purpose

It is well recognized that the number of professionally trained mental health workers, such as psychiatrists, psychologists, and social workers, is inadequate to meet the demands for their services (Albee, 1959; 1963; Cowen, Zax, Izzo, & Trost, 1966; Guerney, 1966; Hobbs, 1964; Joint Commission on Mental Illness and Health, 1961; Ricch, 1966). Of the various approaches suggested to mitigate this problem, two are of interest in the present study. The first involves increasing the number of mental health workers through training persons who have not traditionally been considered for work in this area. The second is the emphasis on mental health programs for children. As Hobbs (1964) stated: "I would urge that we invest approximately 25 per cent of our resources to mount a holding action against the mental health problems of the adult, devoting the major portion, at least 75 per cent, of our resources to the mental health problems of children. This is the only way to make substantial changes in the mental health of our adult population a generation from now (p. 830)."

At present, there is considerable enthusiasm and some support for the proposal that nontraditional workers, with moderate amounts of training and supervision, may make a contribution in psychotherapy and counseling. Successes in training lay persons have been reported in terms of mothers' use of play therapy with their own children (Guerney, 1964; Guerney, Guerney and Andronico, 1966; Stover, 1966), college students as play therapists for emotionally distrubed children (Stollak, 1968), nonprofessional hospital personnel with schizophrenics (Carkhuff & Truax, 1965a), and mature women with adult patients (Rioch, Elkes, Flint, Usdansky, Newman, & Silber, 1963). Guerney (1969) provides comprehensive coverage of possible psychotherapeudic roles for nonprofessionals, parents, and teachers.

There are also a number of studies based on behavior modification techniques which support the possibility of using mothers, teachers, and institutional staff in treating a variety of problems (e.g., Ayllon & Michael, 1959; Davison, 1966; Harris, Johnston, Kelley, & Wolf, 1964; Wahler, Winkel, Peterson, & Morrison, 1965; Wetzel, 1966). However, nondirective play therapy (the focus of the present research) and behavior modification are sufficiently different to suggest that successes with one approach should not be assumed to apply to the other.

The present interest in training future teachers as play therapists was motivated by several considerations. First, evidence of effective functioning by these students could provide a new source of mental health personnel; new roles may be developed for teachers in which they might, under supervision, participate in therapeutic relationships with children needing special help. Without relinquishing their roles as educators, training in play therapy and experience with emotionally disturbed children might increase teachers' motivation for further training in special education or for participating in other programs for the emotionally disturbed . For example, the use of teacher-counselors in Project Re-ED (Hobbs, 1966) suggests that teachers with

relatively little special training can work successfully with children who might otherwise be placed in mental hospitals.

Second, the teacher with training in nondirective therapy may be more effective (and more comfortable) in handling her day-to-day interactions with normal pupils. As Withall and Lewis (1963) have noted, the child's emotional well-being can have a striking effect on his progress in school since a reasonable state of adjustment appears important in education. It is interesting to note that certain teacher characteristics (or approaches) which were positively related to pupils' problem solving ability and productivity (Cogan, 1958; Flanders, 1949) are similar to those considered important in nondirective therapy.

The possibility that teachers may lack important skills and information has been suggested by several authors. Wallen and Travers (1963), in their review of methods of teaching, noted that teacher education does little to generate appropriate patterns of teacher behavior in students of education. They further stated: "Many of the articles... imply that all one has to do is to tell a teacher what pattern to exhibit and that the teacher can then act out this pattern. Such an assumption is, of course, contrary to what is known about the modification of behavior (p. 457)." Kotinsky and Coleman (1955) emphasized the gap between mental hygienists and educators in thinking about the dynamics of behavior and the need for educators to understand children as thoroughly as the knowledge of the times permits.

Third, teachers are likely to encounter emotionally disturbed children in their classes. Clancy and Smitter (1953) in a study based on teachers' reports found that 11 per cent of the elementary school population in Santa Barbara County were considered disturbed with the frequency in some schools as high as 35 per cent. Cowen et al. (1966) reported that 37 per cent of the first-grade children in their study manifested moderate to severe maladjustment. Although there are some indications that elementary school teachers may suggest constructive measures in dealing with children's problem behavior (e.g., Stendler, 1949), there is contradictory evidence. Coxe and Anderson (1944), in studying the extent to which teachers handled 23 common problems in ways which might have therapeutic value, concluded: "In general in dealing with these ... situations the teachers would either defeat their own purposes by making the problem worse, or they would use techniques unrelated to the behavior (p. 544)." It seems likely that teachers with training in psychotherapeutic techniques would be better able to work with disturbed children and handle problems constructively than those who had not had this experience.

In envisioning some of the benefits which may accrue from training teachers in the techniques of nondirective therapy, it should be recognized that the present research represents only a first step in investigating these possibilities. The research reported here was conceived as a pilot study which, if the results were encouraging, would provide a foundation upon which to base further studies and actual programs. Although it was not possible to explore the long-term effects of the experience on students' behavior as teachers, it was believed that the research would be useful in providing evidence for the value of pursuing this approach with teachers.

As indicated in the next section, a number of questions related to the effectiveness of nonprofessionals in working with patients and the importance of training cannot be answered on the basis of existing data. The paucity of research is especially evident with respect to the treatment of children. Consequently, the present study is seen as important in providing much needed data relevant to the use of nontraditional workers in general in meeting the manpower shortage in mental health areas and especially in work with children.

Research Relevant to Nonprofessionals in Mental Health Roles

The literature of the past decade reflects tremendous optimism for the possibility of using nonprofessionals, subprofessionals, lay helpers, and the like in easing the manpower shortage in mental health. While the work of Rioch, Elkes, Flint, Usdansky, Newman, and Silber (1963) was not the first in this area, it was the first extensive investigation of the possibility of training nontraditional persons as mental health counselors. The program of Ricch et al. in which mature housewives received two years of training in psychotherapy provided considerable evidence that the trainees' work with patients was satisfactory and that 61 per cent of their patients showed evidence of improvement. As the authors noted, it was impossible to ascertain the extent to which similar changes might have occurred without intervention since no control group was employed. In any event, this study apparently provided respectability for the notion that persons without an advanced degree in psychology, psychiatry, or social work might make a useful contribution to patients.

It should be noted that the approach of Rioch et al. involved a relatively long training program. Consequently, the findings should not be viewed as evidence that lay personnel who have had no training or quite brief training can function effectively in psychotherapeutic roles. Consideration of the evidence relevant to the effectiveness of lay personnel with little or no training is the major focus of this review.

A recent review (Carkhuff, 1968) lists 21 studies in which there "is extensive evidence to indicate that lay persons can effect significant constructive changes in the clients whom they see (p. 119)." These positive outcomes included work with hospitalized and outpatient neuropsychiatric patients and children. Carkhuff further stated that "selected lay persons, with or without training and/or supervision have patients who demonstrate change as great or greater than the patients of professional practitioners (p. 119)" -- a statement presumably supported by six studies.

Although the number of positive outcomes cited above is fairly impressive and does not exhaust the reports which might be cited, it appears to be time to take a closer look at the evidence relevant to the functioning of nonprofessionals in mental health areas. First, it seems pertinent to ask exactly what data indicate that nonprofessionals are functioning effectively--that they are producing "significant constructive changes." In attempting to answer this question, the comparison of outcome for comparable groups of patients seen by nonprofession-

als or assigned to an "untreated" control condition provides an acceptable basis for comparison. The importance of a no-treatment control group and an adequate experimental design in studies of psychotherapy is well recognized (e.g., Fiske, Hunt, Lubosky, Orne, Parloff, Reiser, and Tuma; 1970; Kelley, Smits, Leventhal, & Rhodes, 1969; Meltzoff & Kornreich, 1970; Paul, 1967).

A second question involves the training of the nonprofessional for his work with patients. If one follows the rather traditional thinking that the capacity to be helpful in the psychotherapeutic relationship is somehow related to training, one is interested in the extent to which various kinds of relatively brief training can prepare the lay worker to provide the therapeutic conditions which have been associated with patient improvement, e.g., accurate empathy, warmth, genuineness. Following this line of thinking, the more successful the nonprofessional is in emulating the therapist-offered conditions provided by professional workers, the more successful he should be with his own clients. It is rather awkward to note (as will be done in the next section) that many of the successes ascribed to nonprofessional workers occurred when the nonprofessional had received little or no training.

Turning to investigations of the effectiveness of nonprofessionals with patients, it may be noted that answering questions about the effectiveness of certain groups of therapeutic approaches is complex. As Paul (1967) has noted, the question, "Does psychotherapy work?" is virtually meaningless. He suggested that the appropriate question is: "What treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances (p. 111)." Unfortunately, the existing research on nonprofessionals is sufficiently limited so that one can, at best, ask whether there is any evidence that these persons can work successfully with patients. A related issue which needs clarification is whether training is important. There are a number of studies which suggest that patients receiving "treatment" from nonprofessionals have shown significant changes (presumably indicative of improvement) in terms of differences between pretreatment and posttreatment measures. Although it is possible that the reported improvements were quite real, the question, Improved compared to whom? often remains unclear. In the studies in which there was no untreated control group, the effects of the treatment variable are confounded by uncontrolled stimulus variables, such as history and maturation (including spontaneous remission) (Campbell & Stanley, 1966). Because the data from studies relying on this one-group, pretest-posttest design are essentially pre-experimental in nature and cannot be adequately evaluated, investigations of this type are not included in the present review.

Investigations employing a no-treatment control group are relatively rare (Carkhuff & Truax, 1965a; Greenblatt & Kantor, 1962; Poser, 1966; Sines, Silver & Lucero, 1961; Verinis, 1970). Of these, the investigation of Sines et al. utilizing psychiatric aides yielded negative results. In this instance, the hospitalized patients treated by the aides (apparently with no special training but participation in 18 seminars) did not differ significantly from the control group

(routine hospital care) in terms of scores on the MMPI or on ratings of adjustment made by psychologists. Since this study focused on the effectiveness of aides in working with patients, the question of training was not considered. Thus it is not possible to know whether aides who received training in therapeutic approaches would have been more effective or, indeed, whether professional mental health workers would have been more effective.

Carkhuff and Truax's (1965a) investigation involved the same five lay hospital personnel whose 100-hour training program has been reported elsewhere (Carkhuff & Truax, 1965b). In this case, the lay personnel conducted group therapy sessions with 80 mental hospital patients while an additional 70 patients received no special treatment. The patients' assignment to the two groups was random and outcome was evaluated after three months. The authors noted that more of the treated than untreated patients were discharged from the hospital, but that the difference was not significant. However, the authors reported significant improvement for the treated group in terms of ratings of ward adjustment as well as significant differences between the treated and untreated groups on measures of psychological disturbances and interpersonal and intrapersonal concerns. Carkhuff and Truax (1965a) concluded:

> "The evidence points to uniformly significant improvement in patients treated by lay group counseling when compared to control patients. The suggestion is that a specific but relatively brief training program, devoid of specific training in psychopathology, personality dynamics, or psychotherapy theory, can produce relatively effective lay mental health counselors (p. 430)."

Meltzoff and Kornreich (1970) have suggested that the Carkhuff and Truax study contains too many weaknesses to provide a basis for optimism. Aside from criticisms involving lack of evidence relevant to the inter- and intrajudge reliability of the measures, Meltzoff and Kornreich stated that the conclusions reached were not supported (or were contradicted) by the data in three instances. Specifically, the data for the variables of psychological disturbance and interpersonal and intrapersonal concerns indicated that the ratio of percentage improved to the percentage deteriorated consistently showed greater deterioration for the treated patients. They suggested that the significant improvement which Carkhuff and Truax reported in conjunction with the chi-square analyses was heavily contributed to by the differential deterioration rate in the two groups. Reanalyses of the data by Meltzoff and Kornreich with the incidence of improvement and deterioration considered separately indicated that for two of the variables the differences between the groups for improvement were not significant. For all three variables, there was significantly more deterioration for the group treated by the lay personnel.

Finally, it may be noted that whatever beneficial effects for patients might be attributed to the lay personnel in Carkhuff and Truax's study, there is no evidence to suggest that these effects were related to the training received by the lay group. As Meltzoff and

Kornreich have suggested, the possibility that the obtained improvement in ward behavior was attributable to the attention given to the treated group cannot be ruled out. The following studies provide further support for this idea.

In contrast to the work of Carkhuff and Truax, the other three studies involved nonprofessional personnel with no training. Greenblatt and Kantor (1962) compared chronic mental hospital patients on a ward which was visited by ward "aids" (college student volunteers) with patients on a similar ward who received only routine care. After a period of two years, the visited patients showed significant improvement in several areas related to conceptual disorganization, activity level, and withdrawal. The authors felt that the fact that 10 patients also earned ground privileges and 3 were sufficiently improved to be transferred to another program was also indicative of the success of the approach. Presumably none of the patients on the control ward showed this type of progress. Lack of information on the total number of patients in each group precluded a test of significance.

The general lack of information about the patients, the measures, and the conduct of the study makes evaluation of Greenblatt and Kantor's study difficult. Presumably a number of different ward aids acted as "quasi-recreational therapists" during the two years during which the study was in progress. Information on the training of the volunteers (if any) and the basis for the ratings of change as well as the reliability of the measures is completely lacking. However, insofar as the patients who were visited by the ward aids improved, this study further suggests that attention may be a relevant variable when chronic neuropsychiatric patients are being considered. Indeed, Greenblatt and Kantor have suggested that the creativity and high drive of the college students probably contributed to their successes in working with this type of patient.

The work of Poser (1966) provides a comparison of groups of chronic schizophrenic patients "treated" by 11 untrained college girls (and 2 inpatients) with similar groups of patients treated by professionals (7 psychiatrists, 6 psychiatric social workers, and 2 occupational therapists), and a no-treatment control group. Following five months of group therapy (routine hospital care for the control group) the patients' performance on several tests (i.e., tapping rate, reaction time, verbal fluency, digit-symbol, Stroop Color-Word Test, and word association) was reevaluated. These measures indicated that the patients seen by the inexperienced therapists improved significantly more than patients seen by the experienced therapists on three of these tests. However, both treated groups of patients showed greater improvement than the control group. These test scores provided the major criterion of outcome, but it may be noted that the discharge rates for the three groups of patients did not differ.

Poser's research has been a favorite target for criticism (Cartwright, 1968; Meltzoff & Kornreich, 1970; Rosenbaum, 1966). Meltzoff and Kornreich believed that a major flaw in the study involved the differential rate of patient drop-out from treatment for the experienced and inexperienced therapists. Although the groups

of patients who were initially assigned to the three conditions were matched on age, sex, severity of illness, length of hospitalization, and test performance on the criterion measures, 48 patients were dropped from the study because of failure to attend the group sessions--43 of the 87 patients assigned to the inexperienced therapists and only 5 of the 145 patients assigned to the experienced therapists. It is possible to wonder why the inexperienced therapists had so many drop-outs and to conjecture about the bias created by the loss of patients. It seems likely that the most uncooperative and unmotivated patients failed to attend the sessions and that this might have differentially affected the outcome measures.

A second major criticism has involved Poser's failure to control age, sex, and therapeutic method since change in patient behavior was supposed to be dependent on one independent variable (training of therapists). The inexperienced therapists were all female and considerably younger than the experienced therapists who were predominantly male. Although the experienced therapists presumably provided traditional therapy, the inexperienced therapists were free to determine the conduct of their groups. Their approach apparently included playing games, parties, dancing, and painting. As Meltzhoff and Kornreich (1970) have stated:

> "Whatever the lay therapists did is not clearly indicated but was obviously something different. The results might reflect an age x sex x method interaction as much or more than training. That is, the improvement rate may reflect the response of middle-aged male patients who had been long institutionalized to the attention given by a group of young college girls coming in with dancing, parties, and other social activities in contrast to their response to conventional group therapy conducted by middle-age professional men. (p. 279)."

The investigation of Verinis (1970) also involved the work of untrained persons (housewives and college students with a 15-minute orientation period) with chronic schizophrenic patients. In this case, the 13 treated and 7 untreated patients were matched with respect to age, sex, and length of hospitalization. The patients were seen on a once-per-week basis for five months. The ward ratings obtained at the end of this period indicated that the treated group had improved more than the control group on all indices with a number of the differences significant. In addition, five of the treated patients had been discharged while none of the control group had.

As with the preceding studies, Verinis recognized the importance of attention: "Another possibility would be that the key therapeutic variable...is centered around the idea that after being lost in the jumble of a typical state hospital, overlooked by both family and staff, having someone from the outside take a warm, sympathetic interest is rewarding to a chronic patient. The message conveyed is that someone does care and someone is concerned (p. 155)."

In summarizing the findings of studies utilizing a no-treatment control group, it is interesting that each of them involved mental hospital patients, usually chronic schizophrenics. One suspects that the use of these captive groups was convenient and did not raise critical issues about the ethics of having patients treated by persons with little or no training. Several comments in the studies suggested that the patients had been receiving only routine hospital care and generally were not considered to be good candidates for psychotherapy. Thus the expectation of positive outcomes on the basis of treatment by nonprofessionals seems somewhat puzzling and unrealistic since the nonprofessionals were treating groups for whom there was little optimism about improvement and little reason to suppose that even well-trained therapists would have marked success. The notion that training may actually be detrimental received some support from the studies which included experienced therapists or lay persons with training. Although Poser's findings are suspect for the reasons noted previously, the contribution of his experienced therapists was not outstanding. They apparently did keep more patients coming to therapy and these patients improved more than the control patients on rather dubious measures of adjustment, but they were not sufficiently improved to be discharged more frequently than the patients in the other groups. Carkhuff and Truax's lay personnel with brief training may have helped patients' adjustment on the ward but they also contributed to their patients' deterioration.

Insofar as a conclusion is possible, any evidence for the effectiveness of the lay workers might well be attributed to the attention that they provided for the patients. It seems likely that the nonprofessionals' contribution had little to do with psychotherapy as it is usually defined and that the implication that they were providing treatment in any traditional sense is simply misleading. The importance of attention, someone caring, etc. seems worthy of greater recognition and the possibility of benefiting patients in this way should be pursued.

Unfortunately, the suggestion that the giving of attention is a major factor in any successes which may be attributed to nonprofessionals in their work with chronic mental patients has not been investigated experimentally with other types of patients in other settings. If our present models for clinical training are correct, there is the strong implication that training <u>should</u> be important in work with many types of patients.

The importance of training in therapeutic techniques involves many issues (e.g., how much and what kind of training) which cannot be considered here. However, the basic question of whether persons with brief training of a particular type can function adequately in particular role is a major concern in thinking about using nonprofessionals in mental health work. Several studies provide some data relevant to this issue in that they involved the comparison of patients seen by persons who varied in amount of training with patients seen by professional workers.

Mendel and Rapport (1963) conducted a study in which the major focus was on the utility of an existential approach to the treatment

of schizophrenics. However, in this context they did compare the successes (or failures) of four groups (psychiatrists, psycholcgists, psychiatric social workers, and psychiatric aides) in maintaining schizophrenic patients outside of the hospital. They reported that 94 per cent of the outpatients seen by psychiatrists had to be readmitted while 36 per cent of those seen by aides were readmitted. While the percentages for the psychologists and social workers were lower (20 and 23 per cent respectively) it was felt that these groups had less difficult patients. In this case, the aides had considerable experience in working with patients, received training in the existential approach, and were selected because of their previously demonstrated ability to work with patients.

The study of Truax and Lister (1970) compared clients seeking rehabilitation counseling under three conditions--counselor (with M.A.) alone, counselor and aide working together, and aide alone. The aides were four applicants for secretarial positions who apparently had no training in counseling but did receive supervision. The clients seen by the three groups were evaluated in terms of ratings made by their training supervisors for their adjustment in eight areas. The clients seen by the aides alone received the highest mean ratings on all variables and were significantly higher than the other groups in four areas. Although this sounds extremely encouraging for the possibility of using untrained persons in rehabilitation counseling, McArthur (1970) has provided a devastating critique of this study. He noted the possibility that variables similar to those mentioned above for schizophrenics may be important. Thus he commented that the age and sex of the aides--"So down and outers did better for pretty girls than for professional men (p. 355)"--as well as a Hawthorne effect are relevant considerations. In addition, he suggested that the unrealistically large case loads of the counselors and aides may have created a situation in which the quick and practical steps that have nothing to do with counseling were taken by the secretaries--"untrained people can do all they know how to do in jig time (p. 355)." His additional contention that the rehabilitation counselors (with M.A.'s) were "half trained" and were not providing a professional service raises further questions about the validity of the comparison between trained and untrained personnel.

Grigg (1961), in investigating counselor performance, compared client's judgments of the helpfulness of the counseling provided by three groups of counselors varying in amount of training and experience; i.e., experienced counselors with Ph.D. degrees, experienced trainees who had completed a year of internship, and inexperienced trainees who had not completed the internship or had had no prior experience. The ratings obtained from the clients at the close of the final interview indicated that the counseling had been "considerably" or "moderately" helpful for 80 per cent of those seen by the Ph.D. counselors, for 89 per cent of those seen by the advanced trainees, and for 85 per cent seen by the beginners. While the similarity of these percentages suggested that the clients' feelings about improvement were independent of the counselors' level of experience, there was some indication that the more experienced counselors had received a higher proportion of more difficult cases. In addition, the percentages of nonresponse

varied inversely with amount of counselor experience (5 per cent for clients of the Ph.D.'s, 14 per cent for advanced trainees, and 17 per cent for the beginners). As Meltzoff and Kornreich (1970) have suggested, these percentages suggest the possibility of a bias in responding. If clients who did not respond tended to have negative evaluations of the counselors, the inexperienced counselors, in particular, would appear to have been more helpful than was actually the case.

As with the studies involving no-treatment controls, it is difficult to formulate any generalization about the importance of training and experience. If the results of each investigation are taken at their face value, persons with some training appeared to do as well as fully trained persons (Mendel and Rapport; Grigg). In contrast, the findings of Truax and Lister suggested that untrained persons performed better than M.A. counselors. When the factors which may have confounded these findings are considered, however, it is apparent that more information is needed before conclusions about training can be formulated.

The second question, whether it is possible to train nonprofessionals in therapy relevant techniques in a relatively short time, has received attention in several studies. Although it is not clear from the investigations of nonprofessionals whether this training is important for effective work with patients, there is considerable literature which suggests that the conditions offered by the professional therapist are important.

The research focusing on process variables and particularly the conditions offered by the therapist in client-centered psychotherapy has received considerable emphasis. As stated by Carkhuff and Truax (1965b):

> "...programs of research into the processes of individual and group counseling and psychotherapy...appear to have identified at least four critical process variables in effective therapeutic processes. The dimensions include: (a) therapist accurate empathic understanding; (b) therapist warmth or positive regard; (c) therapist genuineness or self-congruence; and (d) patient depth of self-exploration. There is extensive evidence to indicate that the three therapist-offered conditions predictably relate to the patient process variable of intrapersonal exploration, and all four dimensions have been shown to relate significantly to a variety of positive patient personality and behavioral change indexes (p. 333)."

Research confirming this statement has been provided by Barrett-Lennard, (1962), Bergin and Solomon (1963), Braaten (1961), Halkides (1958), Rogers (1962), Tomlinson and Hart (1962), Truax (1961), Truax and Carkhuff (1964a; 1964b), and Wagstaff, Rice, and Butler (1960).

Representative of Carkhuff and Truax's (1965b) ideas with respect to the importance of these variables is their study involving the comparison of professional therapists, graduate students in clinical

psychology, and five lay hospital personnel. The lay personnel were trained in a 100-hour program integrating the "didactic intellectual" approach (emphasis on the shaping of therapist behavior relevant to the therapeutic dimensions noted above) and the "experiential" approach (focused on therapist development and growth). Ratings for each of the therapy process variables obtained for the 12 students and 5 lay personnel at the end of training were compared with ratings of these same variables based on random samples of excerpts from tape-recordings of therapy sessions obtained from 15 experienced therapists. Comparisons of the means for the three groups indicated that the experienced therapists consistently ranked higher than the graduate students who in turn ranked higher than the lay therapists on accurate empathy, unconditional positive regard, and therapist self-congruence. The only significant difference between the means for the three groups was that between the experienced and lay therapists for therapist self-congruence. With respect to the one client variable (depth of exploration) the mean for the lay therapists was slightly higher than that for the graduate students but lower than the mean for the professional therapists.

Although the research on process variables, such as accurate empathy, has largely been conducted in the context of nondirective psychotherapy with adults, it appears that the similar process variables have been accepted as a measure of therapist adequacy in studies involving the provision of play therapy by nonprofessionals. The rationale underlying this approach is based on the assumption that if the therapist-trainee can be taught to perform the essentials of the experienced therapist's role, the trainee can function effectively with the child. The therapist variables considered important in providing the appropriate conditions have generally focused on reflection and clarification of feeling or verbal content (as opposed to various aspects of directive verbal behavior).

Several studies have provided evidence that amount and type of training are related to the trainees' performance in nondirective play therapy. Stover's (1966) research involving the training of mothers to do play therapy with their own emotionally disturbed children indicated that for the general category of mothers' reflective behavior, those who received training were significantly higher in this characteristic by the third play session after training than those who received no training. In addition, those mothers whose training in filial therapy was provided by an experienced therapist showed significantly higher levels of reflective behavior than those who were trained by a less experienced therapist.

Stover also investigated several aspects of children's behavior during the play sessions. Her findings indicated that, as hypothesized, children of mothers trained in filial therapy showed significant increases in "active aggression" and "verbal negative feeling" between the first pretraining session and the third session (after training) compared to the children of mothers in the control group who received no training. Similar hypotheses concerning decreases in "verbal dependency" and increases in "verbal leadership" were not confirmed.

A study by Stollak (1968) which investigated training college students to do client-centered play therapy with emotionally disturbed children also indicated that two therapist behaviors, "reflection of content" and "clarification of feeling," showed significant increases in terms of analyses based on the first, fifth, and tenth play sessions. The increase in reflection of content was most pronounced between the first and fifth sessions while the mean scores for clarification of feeling increased over these same sessions and showed a slight decrease in the tenth session. Further comparisons of the student therapists in terms of those considered as high or low potential therapists on the basis of a pretest failed to indicate any significant differences between the groups for either of the variables. Stollak also investigated changes in children's behavior for sessions 1, 5, and 10. In this case, no significant changes were found for "aggressive activity" or "dependency" but there was a significant increase in "negative activity" between the first and the tenth sessions and a significant increase in "leadership" between the first and fifth sessions.

Linden and Stollak (1969) compared groups of college and first-year graduate students who received either didactic training (emphasis on being empathic, reflective, and noninterfering with children), or experiential training (no instruction in therapy; students were, in essence, left to figure out a suitable approach), or no training. The group trained didactically in the principles of client-centered play therapy showed greater use of the techniques considered appropriate for play therapy (e.g., they reflected significantly more feeling and content of behavior, engaged in significantly less directive behavior, and asked fewer questions and restricted less than did the other two groups). The authors suggested that although the experientially trained group might have improved if they had had more training sessions in which to discover the principles, they believed that "the type of 'sensitivity' desired--communicated empathy--is possibly something that even the most empathic or sensitive of us cannot figure out without being taught (p. 217)."

In summarizing the findings relevant to process variables, it is encouraging to note that volunteer hospital personnel after relatively brief training (Carkhuff & Truax, 1965b) demonstrated levels of accurate empathy, etc. which were not markedly different from those of graduate students or professional therapists and that mothers and college students show greater reflectiveness following training than those who had not received such training (Linden & Stollak, 1969; Stollak, 1968; Stover, 1966). However, the assumption that the provisions of one (or even several) appropriate therapist-offered conditions is associated with positive outcomes for children treated by nonprofessionals (or professionals) has not been investigaged. The lack of data on both the outcome of therapy and the relationship of process variables to outcome for children emphasizes the importance of investigating these relationships and is a major focus in the present study.

Research Design and Hypotheses

In order to obtain as comprehensive a picture as possible of the effects of training and experience in nondirective play therapy for the education majors and the effectiveness of treatment for patients, four conditions were employed: experienced therapist, experimental, placebo, and no-treatment control. The experienced-therapist condition involved 12 play interviews provided by psychologists, psychiatric social workers, and advanced graduate students in these fields. In the experimental condition, students majoring in education received 8 sessions of training in nondirective play therapy which were followed by 12 play interviews with emotionally disturbed boys. The approach for the placebo condition was similar except that the training merely emphasized "being a friend." The control condition was defined by no training or experience with play interviews for the education majors and no play interviews or other therapy for the children.

These four conditions in conjunction with pretherapy (pretraining for students) and posttherapy measures and observations and tape-recordings of four of the play interviews (1,4,8, and 12) provided data for investigating three major areas of interest.

The first major aspect of the study involved the assessment of outcome for the children in the therapy and the control conditions. In line with the theoretical expectations relevant to client-centered play therapy and the efficacy of the procedure in terms of the training and experience of the therapists, the following hypothesis was tested:

(1) The outcome for clients in the four conditions ranges from most to least positive (or successful) in this order: experienced therapist, experimental, placebo, and control.

The problems associated with assessing change led to the adoption of two different approaches which may be thought of as idiosyncratic and normative. The idiosyncratic approach was based on Target Complaints, a method proposed by Battle, Imber, Hoehn-Saric, Stone, Nash, and Frank (1966). The Target Complaints provide a measure of change after treatment in terms of the particular problems which the client (in this case the children's parents and teachers) indicated they would like to have eliminated through therapy. This approach appears to be especially felicitious when patients are heterogeneous with respect to the problems which created the need for therapy (as they were in the present study).

Although it may be argued that the Target Complaints do not actually represent the "true" or "deeper" problems which have contributed to the child's maladjustment, they may be regarded as one useful criterion of change as observed by the child's parents and teacher in the life situation. This approach which utilizes tailored criteria of change is consonant with the recommendations of Rickard (1965) and provides a way which may not be appropriate for all patients. (This measure as well as others which are briefly noted in this section are described in detail in the section on Measures).

The two normative approaches involved the comparison of children's pretherapy and posttherapy scores on general measures of adjustment without reference to the particular problems that led to referral. These included the Incomplete Sentences Blank (Rotter & Rafferty, 1950) obtained from the children and scored for adjustment, and a semantic differential technique based on the work of Becker (1960) and Hobbs (1966). The Semantic Differential was used in obtaining a pre- and posttherapy picture of the children as reported by mothers, fathers, and teachers.

Although it seems reasonable to suppose that changes in some variables are generally indicative of improved adjustment (e.g., reduction of conflict responses on the Incomplete Sentences Blank), this assumption seems doubtful for other variables. Thus while it might be argued that decreases in aggressiveness following therapy are indicative of improvement, a child who was shy, nonassertive, and somewhat withdrawn at the beginning of therapy might be considered better adjusted if he were somewhat more aggressive. This problem may be further aggravated in a heterogeneous sample in which only a few of the subjects may be characterized by high scores in some characteristic (such as hyperaggressiveness). A possible solution to the problem of investigating change in terms of the large variety of characteristics included in the Semantic Differential was explored through the application of factor analysis. Becker's (1960) finding of quite similar factors for the responses of mothers, fathers, and teachers of the young children comprising his sample, suggested that a similar approach might be applied to the responses in the present study. These factors might then be used as a basis for comparing the children on the pre- and posttherapy measures and for investigating change in terms of the specific patterns of behavior represented by the factors.

The Semantic Differential was also of interest because of Hobb's (1966) work with a brief form of a similar instrument. He reported that mothers' and fathers' ratings of their severely disturbed children were obtained before and after the children's participation in Project Re-ED ("a project for the re-education of emotionally disturbed children"). On each occasion, the parents rated their child as they perceived him and their standards for him. Comparisons of the two sets of ratings indicated that both parents tended to perceive their child as having improved after participation in the program. Hobbs noted, however, that there was a "dynamically significant" difference between mothers and fathers with respect to their standards for the child and changes in these associated with perceived change. For fathers, the perceived improvement was characteristically associated with a lowering of standards. For mothers, the perceived improvement was frequently associated with an increase in standards so that the discrepancy between their perception of the child and their standards for him tended to remain similar for the before and after measures even though the child had improved. Although no data or statistical analyses were reported, Hobbs' findings are intriguing both in terms of the use of the semantic differential as a measure of outcome and especially because of the differences between mothers and fathers related to changes in standards. Consequently, the relationships between pretherapy and posttherapy

measures of parents' perceptions of their child (actual scores) and their standards for him (ideal scores) were investigated in the present study.

In addition to providing somewhat different bases for evaluating the effect of the experimental conditions, the three measures of outcome made it possible to investigate the relationships among the measures. It was hoped, of course, that the two types of parent and teacher measures (Target Complaints and the Semantic Differential) would be positively correlated with each other and with the child measure (Incomplete Sentences), as well as providing evidence of agreement among the adult respondents on a particular measure.

It is possible, however, that the outcome measures are assessing rather different aspects of children's adjustment and behavior and may show little relationship. The problem of measuring change or improvement related to psychotherapy has long been recognized in work with adults and is no less complicated for children. Indeed, the paucity of research on the outcome of psychotherapy with children and the difficulty in obtaining direct measures from young children compound the problem of selecting reliable and valid measures. It seemed worthwhile, therefore, to use a multifaceted approach in the present study which would provide various possibilities for assessing change as well as an opportunity to learn more about the measures.

The second major aspect of the present research involved the comparison of the behavior of the student therapists (experimental and placebo conditions) and the experienced therapists during the play interviews. In line with theoretical expectations and the findings obtained by others in similar research involving process variables in play therapy it was hypothesized that:

(2) Therapist performance in terms of variables considered relevant to success in play therapy ranges from most to least satisfactory for the experienced therapists, students in the experimental condition, and students in the placebo condition.

The measures of therapist characteristics in terms of reflectiveness, directiveness, and several other categories were based on the observations and transcribed tape recordings of four play interviews for each child. The variables and criteria for rating them were obtained primarily from the work of Stover (1966) and Moustakas, Sigel, and Schalock (1956).

A second measure of therapist performance was based on the final (twelfth) session in which the complete transcript of the session was rated for the same therapist variables as those used by Rioch et al. (1963).

The third area of investigation involved consideration of the effect of participation in the training sessions and play interviews on the education majors in the experimental and placebo conditions in contrast to those in the control condition. Although none of the research

involving the training of subprofessionals in nondirective play therapy has investigated change in trainee attitudes, it seems reasonable to suppose that the experiences of students in the experimental condition in particular might be reflected in more positive attitudes toward children and in increased empathy and understanding of children and their problems. It was hypothesized, therefore, that:

(3) Students in the experimental condition show significantly greater evidence of positive attitudes and greater empathy toward children on the posttherapy measures than students in the placebo and control conditions.

The assessment of students' attitudes toward children was based on the Minnesota Teacher Attitude Inventory (Cook, Leeds, & Callis, (1951). This instrument, according to its authors, is designed to measure those attitudes of a teacher which predict how well he will get along with pupils in interpersonal relationships and indirectly how well satisfied he will be with teaching as a vocation. In addition to evidence of validity presented by the authors (Cook & Leeds, 1947; Leeds, 1950; Leeds & Cook, 1947), the research of Scott and Brinkley (1960) suggested that changes in the attitudes of student teachers varied on the basis of their supervisors' attitudes, e.g., students whose supervisors' attitudes were superior to their own improved significantly while those whose supervisors' attitudes were inferior did not change.

A second measure utilizing students' stories elicited by selected pictures from the Michigan Picture Story Test (Andrew, Hartwell, Hutt, & Walton, 1953) was developed for the present study. Although the Michigan Picture Story Test has typically been used with children, the pictures include a number of adult-child interactions which appeared appropriate for eliciting stories relevant to the variables of interest here. In scoring the stories obtained in the pretraining and posttherapy periods, three variables were considered: (1) the focus of the story--the extent to which the child or adult was the main character or "hero"; (2) the storyteller's orientation toward the child in terms of understanding and attention to his motives and feelings; and (3) the storyteller's presentation of the adult in terms of his consideration for and understanding of the child. The scores for the "child" and "adult" ratings were considered to be the main variables of interest in evaluating posttherapy differences in attitudes between the groups.

Although a more definitive measure of the students' attitudes toward children and their capacity for working with their pupils would have been desirable, the follow-up of the student subjects as teachers was not within the scope of the present study. It was hoped, therefore, that the measures noted above might provide some evidence relevant to changes in attitudes which might, if they exist, generalize to the classroom.

A fourth and rather ancillary area of investigation involved the use of the student pretraining measures (as noted above) and the students' responses to the Incomplete Sentences Blank (Rotter & Rafferty, 1950)

as measures of characteristics which might be related to success in working with patients. To explore this possibility, the three pretraining measures were correlated with several of the therapist variables assessed during the play interviews and with the child outcome variables. Although the groups were small, the paucity of information relevant to personality factors related to success in training and therapy suggested that any evidence of relationships would be useful in providing a basis for further investigation.

Method

Subjects

Two major groups of subjects were involved: (1) The therapists and controls including education students and experienced therapists, and (2) the child patients and their parents and teachers.

Student and Experienced Therapists. The student subjects were 40 female education majors at Loyola University and Mundelein College, Chicago. The majority were juniors and seniors and all were in good academic standing and had no direct experience with psychotherapy (personal, member of family, or training). All were volunteers who agreed to continue for a period of four to five months and all who indicated willingness to participate were included. The students were paid $1.50 per hour for all time devoted to the project (i.e., testing sessions, training, and play sessions).

The students were assigned to one of the following conditions: (1) training in nondirective techniques plus 12 play interviews (experimental group); (2) "training" in being friendly plus 12 play interviews (placebo group); (3) no training or playroom experience (control group). The assignment of subjects to these conditions was determined by the availability of the student for the training sessions. Students who could not be available for training with either trainer were assigned to the control group. Attrition among the students assigned to the experimental and placebo groups was low (two placebo subjects discontinued training for personal reasons). However, four of the nine subjects initially assigned to the control group failed to return for their posttests. To supplement the control group, the students in one education class were tested and the nine students who met the criteria noted above and were willing to volunteer for training and play sessions were assigned to the control condition.

While the assignment to groups was not random, it was believed that the approaches used did not contribute to a selection bias. It may be noted that the available background information was not considered in making assignments and scores on the pretests were not available at the time assignments were made. The comparability of the groups is supported by the data presented in Table 1. The means and standard deviations for the variables of age, semesters in college, grade-point average (GPA), and number of courses in psychology indicated that the three groups were very similar. The only significant difference between groups was obtained for number of education courses where the experimental group had significantly more courses than the control group ($t = 2.07$, $p = .05$). The final

Table 1

Background Information for Student Therapist Groups

Group		Age (Years)	Semester in College	GPA	Number of Courses: Psychology	Number of Courses: Education	Pretest to Posttest (Days)
Experimental	M	21.36	5.57	2.64[1]	2.50	4.29	160.64
(N = 14)	SD	1.24	1.12	.43	1.55	2.37	36.63
Placebo	M	21.29	5.08	2.68	2.50	3.08	158.20
(N = 12)	SD	.86	1.11	.47	1.50	2.02	42.32
Control	M	21.91	5.07	2.68	2.21	2.29	100.64
(N = 14)	SD	3.88	1.27	.38	1.26	1.38	27.96

[1] On basis of 4-point system.

variable, elapsed time between the pretest and the posttest, showed significant differences which indicated that this period was significantly shorter for the control group than for either the experimental or the placebo groups (t = 3.35 and 2.84 respectively, $p < .01$). These differences are attributable to the fact that the nine control subjects tested in the education class were easily available only during a single semester and received the posttest sooner than the other subjects. Other data relevant to the comparability of the groups in terms of pretest scores are presented in the results section.

The experienced therapists consisted of four psychologists and five social workers affiliated with the Loyola University Guidance Center. All were female and their experience with play therapy and work with children ranged from 9 months to 7 years with a mean of 2.6 years. In terms of education, two had their Ph.D. degrees and two had their M.A. degrees in clinical psychology, two had their M.S.W., and three were graduate students in social work who were about to receive their M.S.W. Each therapist conducted play interviews with only one child with the exception of one therapist who saw three children. Although all of the therapists were familiar with the principles of nondirective play therapy, it became apparent during the course of the study that most used a rather eclectic approach including more active participation and directive techniques. In the choice between trying to have the therapists conform to the nondirective approach or having them follow their customary approaches, it was decided that the latter would probably yield results which would be more representative of this group.

Children, Parents, and Teachers. The 48 child subjects were boys between 8 and 12 years of age. They were obtained through routine referrals to the Guidance Center. During the period of the study, all boys who met the criteria of age, were from intact families, and were attending school were considered as eligible. Those with the diagnosis of brain damage, mental retardation, or severe behavior disorder were excluded. In addition, both parents had to be willing to participate in interviews, to answer questionnaires, and to give permission for information obtained on their child to be used in research. The parents also had to be willing to have their child's teacher provide information on his school behavior. In terms of the parents' willingness to have their child participate in what was termed the "Special Training Project," the following points were made clear: (1) for children who would be seen by the education students, it was explained that the therapist would be a student in training who would receive supervision from an experienced psychologist; (2) the play therapy was limited to 12 sessions at which time the child would be re-evaluated and he might continue at the Guidance Center if the parents and staff deemed it desirable; (3) the therapy sessions would

start immediately--as opposed to the rather usual delays imposed by waiting lists; (4) the fee--based on the parents' ability to pay--would be one-half of the usual amount. Parents of children seen by the experienced therapists were also informed of the 12 session limit before re-evaluation and were offered treatment immediately with the reduced fee. For those who would be assigned to the control condition (a 3-month waiting period), the parents were informed that the child would enter therapy as soon as a therapist became available.

With one exception, all eligible parent-child pairs agreed to participate in the project. It may be noted that no child in any of the three therapy conditions failed to complete the 12 sessions. However, 5 of the 16 children initially assigned to the control condition were unavailable for the tests and interviews following the waiting period. The reasons for not accepting treatment included two instances of illness in the family and three cases in which the parents simply indicated they were no longer interested.

Assignment to the four conditions was based largely on expediency with the first children being assigned to the experimental and placebo conditions. This was necessitated by the fact that 26 children were needed as subjects for the 26 students trained during the first year of the project. The assignment of children to the two student conditions was random in that each student selected a slip of paper which contained the name of a child. During the second year a paucity of eligible children suggested that the assignment of subjects to the experienced-therapist condition should be completed first and that the assignments for the control condition should be made later in the event that insufficient subjects were available. Assignments to the experienced therapists were based on therapist availability and no attempt was made to assign particular children to particular therapists.

In terms of several types of background information available for the children assigned to the various conditions, the four groups appeared comparable. Table 2 shows the means and standard deviations for each group for age, grade in school, and socio-economic class. The ratings of socio-economic class (Coleman, 1959) were based on father's occupation with ratings of "1" and "7" defining the lowest and highest classes respectively. In all conditions, the children's parents were predominantly of Roman Catholic background (74.5% both parents, 12.5% one parent). None of the differences between the groups was significant. Additional data relevant to the comparability of the four groups in terms of scores on the pretests are provided in the results section.

Table 2 also shows the means for each group for elapsed time between the pretest and the posttest and the mean time in therapy.

Table 2

Background Information for Children

Group		Age (Years)	Grade in School	Socio-Economic Class	Pretest to Posttest (Days)	Time in Therapy (Days)
Experienced T	M	9.96	4.18	4.63	125.55	76.45
(N = 11)	SD	.75	.94	1.15	37.79	26.18
Experimental	M	10.05	3.85	4.00	120.79	92.21
(N = 14)	SD	1.40	1.51	1.18	7.69	14.89
Placebo	M	10.40	4.36	4.00	137.08	92.42
(N = 12)	SD	1.48	1.67	.95	25.31	13.49
Control	M	10.76	4.67	4.00	95.64	
(N = 11)	SD	1.25	1.00	1.07	12.77	

While time in therapy was comparable for all conditions ($F = 2.66$ for df 2,34; p .05), the means for elapsed time between the pretest and posttest were significantly different ($F = 5.84$ for df 3,44; p .01). The mean for the placebo condition was inflated by the fact that two subjects did not return for the posttest for 191 and 187 days respectively and because the subjects in the control condition tended to return earlier than subjects in the other conditions. This shorter period was due, in part, to the fact that the waiting period was envisioned as comparable to the period of therapy (3 months).

Measures

Student Measures. The Minnesota Teacher Attitude Inventory (MTAI) developed by Cook, Leeds, and Callis (1951) consists of 150 items investigating teachers' attitudes toward pupils. The respondent marks each item in terms of five options ranging from "Strongly Agree" to "Strongly Disagree." Scoring followed the instructions provided in the manual (Cook et al., 1951) and the total score was the sum of the responses keyed as "rights" minus the responses keyed as "wrongs."

The Incomplete Sentences Blank (ISB) developed by Rotter and Rafferty (1951) consists of 40 items (see Appendix A). Scoring was based on the criteria provided in the manual (Rotter and Rafferty, (1950). All scoring was performed by an undergraduate psychology major with all the records coded so that information on the time of testing and the subject's assignment to one of the conditions was not available. The total score was the sum of the ratings for the individual items with the higher scores indicating greater conflict or maladjustment. The reliability of the scoring procedure in terms of interrater agreement was assessed by correlating the scores for 10 randomly selected records scored by the author with the scores obtained by the student. The correlation (r) was .96.

Seven plates from the Michigan Picture Story Test (Andrew et al., 1953) provided the basis for rating three variables: Focus, Child Scale, and Adult Scale. Each of these variables was rated on a 5-point scale for each of the stories produced under instructions similar to those used for the Thematic Apperception Test. In brief, the ratings for Focus ranged from adult focus with emphasis on the adult's actions and point of view (1 point) to child focus in which the emphasis was on the child's actions and point of view (5 points). For the Child Scale, the lowest rating (1 point) was assigned to stories in which the storyteller restricted herself to a description of the situation or problem with no attention to the thoughts, feelings, or needs of the child. The highest rating (5 points) was assigned when the storyteller emphasized the feelings, motives, thoughts,etc. of the child in such a way that the story provided a

picture of the child as a real and fairly unique person. The ratings for the Adult Scale ranged from a description of the adult as clearly and actively negative or hostile toward the child (1 point) to the adult as distinctly positive toward the child, e.g., showing a high level of awareness of the child's needs and problems and/or showing thought and concern in planning for the child (5 points). The descriptions of the pictures and the complete scoring manuals developed by the author are shown in Appendix A.

The total score for each of the Michigan Picture scales was the sum of the ratings assigned for all pictures. All scoring was performed by the author with the records coded so that no information was available on the subjects' assignment to one of the conditions or the time of testing. An estimate of interrater agreement was obtained by having another psychologist rate 20 randomly selected protocols following the instructions provided in the manual. The product-moment correlations (r_s) were .76 for Focus, .75 for the Child Scale, and .67 for the Adult Scale.

Child Measures. The Incomplete Sentences Blank (ISB) (Rotter & Rafferty, 1950) provided the only direct measure of the child subjects in the pre- and posttherapy periods. Although the items were the same as those used in testing the therapists and may not be entirely appropriate for a younger group (Rotter, Rafferty, & Lotsof, 1954), the stems were those used at the Guidance Center in testing a variety of young children. In addition, the lack of a published scoring manual for younger students made it necessary to use the existing manual with the changes in scoring suggested by Rotter et al. (1954) and as clinical judgement dictated.

All pretests and posttests for subjects in the four conditions were coded to remove identifying information before being scored. All ratings were made by the same student who scored the ISB for the student therapist groups. Since a scoring required somewhat more reliance on judgement, interrater agreement was again investigated. The author scored 10 randomly selected records and the correlation between the scores obtained by her and the rater was again quite high (r = .86).

Two measures relevant to outcome and change for the child subjects were obtained from their parents and teachers. The measure of Target Complaints was based on the approach of Battle et al. (1966). In applying this approach to children, each respondent was asked what problems he would most like to have the child receive help with in psychotherapy. For the pretherapy measure, the interviewer saw each parent separately and recorded the problems verbatim. Each parent then rated each of the problems on a 13-point scale indicating the severity of the problem where 1 indicated "No problem at all" and 13 indicated "Couldn't be worse." In the posttherapy interview, each

parent was presented with the problems he had stated previously and was asked to rate the present status of the problem on a 7-point scale where 1 indicated "Much worse" and 7 indicated "Much better" and 4 was a neutral point representing "No change." The complete instructions and rating sheets are shown in Appendix B.

The scores for severity and for change for each parent were the mean of the ratings for all problems.

For the teachers, the approach was similar except that they responded to a questionnaire sent by mail and no rating of severity was obtained (see Appendix B).

The Semantic Differential for Parents and Teachers was based on the work of Becker (1960) and Hobbs (1966) and consisted of 67 items, each representing a bipolar trait, e.g., warm--cold, happy--sad. The majority of the bipolar traits included in the present measure were those which had proved useful in defining factors in Becker's work. A few additional items plus the format for administering the measure were provided by the version used by Hobbs (personal communication, 1968).

In the "actual" administration, each respondent was informed that "We would like to have a general picture of (child's name)." In the "ideal" administration, the respondent was informed: "Now we would like to know your feelings about how you would like to have (child's name) behave." The complete Semantic Differential plus the instructions for its administration are shown in Appendix B.

The order of the items was the same for both forms of the measure. However, to avoid a possible position bias which might occur by always having the positive aspect of the antonym pair at the right or left, the positive and negative descriptive terms were alternated on a random basis.

A score for each bipolar trait was obtained by assigning ratings of 6, 5, or 4 to the ratings of "Very," "Moderately," and "Slightly" respectively for the positive aspect of the trait and 1, 2, and 3 for "Very," "Moderately," and "Slightly" respectively for the negative aspect of the trait. On the few items where a respondent did not follow the instructions for making only one rating per item or failed to make a rating, certain conventions were established so that a score would be available for all items. When the respondent had checked two categories for an item (apparently indicating the range of the behavior or characteristic), the average of the two ratings was used. When a parent omitted an item on one of the actual measures, the rating made by the other parent was substituted. When a teacher omitted a rating on one of the actual measures, the average of the ratings made by both parents for that item was used. Omissions

from the ideal ratings were eliminated by substituting the ideal rating the parent had made for that item on the pretest or the posttest.

These 6-point ratings for the pretest-actual measure provided the item scores used in the factor analysis. The total score for each measure (pretest actual and ideal, posttest actual and ideal) was the sum of the ratings for all items comprising that measure.

The factor analyses for the Semantic Differential were based on the pretest-actual item scores for all available respondents (54 mothers, 52 fathers, and 51 teachers). These Ns included several parents and teachers of control subjects who were not included in other analyses because of failure to return for the posttests.

A separate factor analysis was obtained for each respondent group and the total (the pooled scores of the three subgroups). First, the correlations among the 67 items for each subgroup and the total were used in obtaining the principal components. The 10 components which were extracted initially and the patterns of eigenvalues were examined. One more component than was suggested by the eigenvalues was rotated using Kaiser's (1958) normal varimax rotation. Examination of the resulting factors and the three subgroups and the total suggested that six factors accounted for most of the variance. The subsequent analyses used a modification of the procedure described by Harris and Kaiser (1964) to obtain both the independent cluster patterns and the oblique solutions for six, five, and four factors.

Inspection of the factors and item loadings for each of the three subgroups and the total suggested that the four-factor solution was the most satisfactory in that four very similar factors were obtained for each group. These similarities had also existed in the five- and six-factor solutions, but in these cases the groups tended to have one or more factors characterized by a small number of items which varied from group to group or overlapped items included in one of the major factors for another group. The similarity of the four-factor solution for the three subgroups and the total is well illustrated by the fact that 61 items met the criteria for inclusion in one or more of the factors as noted below.

The selection of items for each of the factors was based on the following principles: All items having loadings of .30 or higher on a particular factor for three of the four analyses (i.e., mother, father, teacher, and total) were considered. No item was included in more than one factor unless the loading was negative for one factor and positive for the other. This approach resulted in the double inclusion of only four items (9, 17, and 22). In the few instances in which an item qualified for inclusion in two factors and carried the same sign for each, the item was assigned to the factor

on which it had the higher loading for the total group. This occurred in only four instances (items 11, 14, 56, and 57).

Tables 3 through 6 show the items comprising the four factors and the loadings obtained for each of the items. In presenting the items, the following conventions have been followed: (1) factor loadings have been made positive with the description of the variables reversed where necessary; (2) the first term in each antonym pair represents the higher score.

In naming the factors, the prior work of Cattell and Coan (1959) and Becker (1960) with similar items was considered. In general, the present factors appear closer to those obtained by Becker than to those of Cattell and Coan.

Factor I with generally high loadings for self-contained, calm, patient, easy going, and relaxed is similar to Becker's Factor 2 (Relaxed Disposition vs. Nervous Disposition) and Factor 3 (Lack of Aggression). The element of aggression is represented in the present Factor I by such items as prone to tantrums, prone to anger, demanding, and difficult to discipline. While it might be supposed that these two types of items represent separate factors which were obscured in the four-factor solution employed here, it may be noted that these items tended to occur together in the previous solutions involving more factors. Consequently, Factor I will be referred to as Relaxed-Nonaggressive vs. Nervous-Aggressive. This factor is, in a sense, the one that reflects more aspects of adjustment vs. maladjustment.

Factor II is described by the following variables: friendly, happy, loving, and warm vs. not friendly, depressed, not loving, and cold. It contains a number of variables which characterized Becker's Factor 1 (Hostile-Withdrawal vs. Warm-Extrovert). It is intersting to note that the item"extraverted-introverted" which loaded on this factor in Becker's analysis did not load on any factor in the present analysis. While the implications are similar, this factor will be referred to as Happy-Sociable vs. Withdrawn-Hostile.

Factor III, with the highest total loadings for organized, adult-like, responsible, and meaningful vs. disorganized, infantile, irresponsible, and meaningless, bears some similarity to Cattell and Coan's Factor 1 (Super-ego Strength vs. Dependent Character). It also contains items which described Becker's teacher factor and Factor 5 (Conduct Problems). In this instance, the variables which are similar to those of the teacher factor frequently had low loadings for the teachers in the present sample (e.g., intelligent-dull minded: loading of .08; deep-shallow: loading of .22). Factor III also failed to include items which appeared to be especially important in delineating Becker's Conduct Problem (e.g., disobedient, difficult to discipline, not helping, lying). Although

Table 3

Items and Factor Loadings for Factor I:
Relaxed-Nonaggressive vs. Nervous-Aggressive

Item		Mother	Father	Teacher	Total
47.	Self-contained - Emotional	.75	.45	.99	.94
38.	Calm - Excitable	.65	.74	1.05	.83
18.	Patient - Impatient	.49	.70	.84	.80
24.	Easy going - Irritable	.75	.59	.66	.77
15.	Uninquiring - Curious	.33	.47	.65	.76
26.	Not prone to anger - Prone to anger	.75	.78	.78	.73
10.	Not demanding - Demanding	.60	.83	.74	.72
13.	Not jealous - Jealous	.63	.74	.62	.72
45.	Relaxed - Tense	.53	.66	.43	.70
60.	Not prone tantrums - Prone tantrums	.52	.88	.83	.70
54.	Placid - Nervous	.54	.68	.75	.68
52.	Attention avoiding - Attention seeking*	.60	.26	.90	.64
41.	Nonchalant - Anxious	.53	.37	.46	.61
22.	Colorless - Colorful *	.36	.41	.47	.60
31.	Quiet - Noisy	.39	.37	.92	.51
6.	Submissive - Dominant *	.76	.45	.66	.49
51.	Easily disciplined - Difficult discipline	.49	.47	.61	.40
43.	Obedient - Disobedient	.42	.25	.66	.31
48.	Weak willed - Strong willed *	.33	.65	.19	.31
50.	Modest - Exhibitionistic	.59	.36	.88	.24
61.	Adjusted - Maladjusted	.62	.51	.41	.12
4.	Kind - Cruel	.49	.33	.52	.04

*Negative loading before reversal of terms

Table 4

Items and Factor Loadings for Factor II:
Happy-Sociable vs. Withdrawn-Hostile

Item		Mother	Father	Teacher	Total
62.	Friendly - Not friendly	.58	.51	.86	.80
7.	Happy-Depressed	.35	.54	.88	.76
63.	Happy - Sad	.26	.53	.84	.76
9.	Loving - Not loving	.62	.57	.81	.75
17.	Warm - Cold	.51	.77	.79	.67
11.	Trusting - Not trusting	.31	.40	.71	.66
21.	Soft-hearted - Hard-hearted	.35	.75	.69	.69
16.	Optimistic - Pessimistic	.45	.31	.77	.62
3.	Sociable - Unsociable	.67	.23	.74	.62
23.	Outgoing - Self-centered	.51	.46	.62	.56
57.	Cooperative - Obstructive	.32	.37	.43	.51
19.	Responsive - Aloof	.62	.44	.48	.50
55.	Helping - Not helping	.52	.05	.57	.47
22.	Colorful - Colorless	.56	.76	.45	.36

Table 5

Items and Factor Loadings for Factor III:
Mature vs. Immature

Item		Mother	Father	Teacher	Total
59.	Organized - Disorganized	.62	.39	.58	.66
56.	Adult-like - Infantile	.62	.62	.43	.65
53.	Responsible - Irresponsible	.70	.46	.27	.64
27.	Meaningful - Meaningless	.63	.72	.62	.64
46.	Able concentrate - Subject distraction	.42	.43	.60	.60
5.	Conscientious - Conscienceless	.75	.51	.11	.57
58.	Effective - Ineffective	.60	.05	.74	.51
40.	Neat - Disorderly	.50	.45	.37	.50
28.	Interesting - Boring	.46	.35	.42	.48
33.	Deep - Shallow	.70	.55	.22	.47
25.	Real - Unreal	.30	.35	.25	.45
8.	Intelligent - Dull minded	.38	.57	.08	.30

Tabl 6

Items and Factor Loadings for Factor IV:
Active vs. Passive

Item		Mother	Father	Teacher	Total
12.	Tough - Sensitive	.47	.76	.62	1.07
34.	Not fearful - Fearful	.38	.62	.82	.92
29.	Confident - Feels inadequate	.46	.44	.54	.83
39.	Conceited - Self-critical *	.44	.68	.29	.80
21.	Hard-hearted - Soft-hearted	.13	.48	.45	.74
49.	Independent - Dependent	.62	.53	.00	.71
9.	Not loving - Loving *	.34	.32	.25	.66
67.	Outdoor type - Indoor type	.63	.70	.06	.64
20.	Adventurous - Timid	.51	.68	.28	.63
32.	Masculine - Feminine	.79	.23	.71	.61
64.	Leader - Follower	.52	.44	.26	.61
17.	Cold - Warm *	.26	.32	.31	.40
66.	Never seems tired - Tires easily	.60	.61	.05	.52
65.	Always on go - Not active	.41	.71	.14	.45
14.	Quick - Slow	.51	.60	.34	.39
30.	Formed - Formless	.88	.18	.52	.38
1.	Active - Inactive	.58	.43	.14	.32

*Negative loading before reversal of terms.

Cattell and Coan's notion of super-ego strength appears relevant, Factor III will be referred to as simply Mature vs. Immature.

Factor IV has parallels in Cattell and Coan's Factor 2 (Dominance vs. Submission) and Becker's Factor 4 (Submission - Dominance). The present factor includes more variables than that of Becker and, rather interestingly, the items "dominant-submissive" and "strong willed-weak willed" did not load on this factor (see Factor I). The variables describing this factor include tough, not fearful, hard-hearted, independent, and masculing vs. sensitive, fearful, soft-hearted, dependent, and feminine. The impression is that of an active, "all boy," outdoor-type who is neither loving nor warm. In view of the somewhat different emphasis for this factor, it will be referred to as Active vs. Passive.

The four factors obtained for each group of respondents were then used in obtaining scores for the separate factors. The "ideal variable" method (Holzinger & Harmon, 1941, pp. 286-288) was selected as the approach which seemed most applicable to the data. Further discussion of this approach is provided by Horn (1965) and Harris (1967, p. 372). The application of this method yielded separate factor scores for the pretherapy and posttherapy measures for mothers, fathers, and teachers. Although the use of factor scores specific to each of the respondent groups did not permit comparisons between mothers', fathers', and teachers' scores except through correlation, they did provide a meaningful basis for evaluating changes in children's behavior as perceived by each group of respondents.

Therapy Measures. All measures of therapist behavior were based on transcripts of tape recordings of the four play interviews (1, 4, 8, and 12) accompanied by minute-by- minute descriptions of the therapist-child interactions based on observations of the interviews. Synchronization of the observations and the verbalizations from the tape recording were possible through the use of a timer connected to the tape recorder which produced a beep at 1-minute intervals. This beep was recorded on the tape and was also audible to the observer who could then note the activities in progress during each minute.

The observations of the play sessions were largely made by undergraduate students majoring in psychology. They were paid $1.50 per hour and were naive with respect to the various conditions under investigation and the major hypotheses of the research. The observers received brief training in making systematic observations and instructions in using the tape recorders. The observer made no ratings of behavior during the sessions and were simply told to describe what activity was in progress during each minute as well as commenting on obvious aspects of the child's affect and reactions. It should be noted that the ratings based on the transcripts of the sessions (described later) relied heavily on the tape-recorded verbalizations rather than on the observations since it was realized that some observers provided more detailed (and probably more accurate)

descriptions of the child's affect, facial expression, etc. than others. Because the observations were used largely to provide the context for the verbalizations, no estimates of interrater agreement were obtained.

The process ratings were based on the first 30 minutes of the four transcribed interviews for each therapist-child pair. The system for rating the interviews was derived from the work of Moustakas, Sigel, and Shalock (1956), Ashby, Ford, Guerney, and Guerney (1957), and from the more recent application of the latter system by Stover (1966).

In selecting the categories to be used in coding the therapists' verbalizations, an effort was made to provide sufficient categories so that fairly distinctive and theoretically important types of responses might be coded separately but, at the same time, to avoid having categories which were seldom used. The following 12 categories appeared to meet these criteria: Conversation; Seeking Personal Information; Seeking Impersonal Information; Orienting and Directing Responses; Positive Comments, Negative Comments; Simple Recognition; Solicited Cooperation, Help, and Information; Reflection and Clarification of Content and Feeling (three levels), Reflective Leads; Reflective Structuring; Unclassified Responses. The Conversation category is unique for the present study and was utilized because many of the verbalizations of the therapists appeared to be exactly that. The manual describing the coding procedure and directions for coding these categories is presented in Appendix C.

Although the possibility of grouping these categories in terms of directive and reflective approaches (as followed by Stover) was considered, some quite frequent types of responses (e.g., Simple Recognition; Solicited Cooperation, Help, and Information) were difficult to classify. For example, Simple Recognition (Um-hmm, Yes, I see) suggests responses which are characteristic of the reflective approach. However, this category was also frequently used in conjunction with more directive and conversational approaches. Consequently, it appeared that its categorization as a reflective response would tend to inflate the scores for the reflective category without delineating responses that were especially typical of that approach. Because of this and similar problems, the directive-reflective dichotomy was not used and the scores for the 12 categories were considered under 7 headings for the purposes of the statistical analyses. In this approach, the following four categories were grouped as Miscellaneous Responses: Simple Recognition; Solicited Cooperation, Help, and Information; Seeking Impersonal Information; and Unclassified Responses. In addition, the three reflective categories were considered together as Reflective Responses. The remaining categories were considered separately.

The score for each of these seven categories was the total frequency of therapist verbalizations coded for the category. The total score was the sum of the frequencies for the seven categories plus responses which could not be coded because of difficulty in hearing what the therapist had said. In addition to comparisons based on these scores, the scores for each category were considered as proportions of the total number of responses varied greatly from therapist to therapist and the proportion (or percentage) of the times that she responded in a particular way appeared more adequate in representing the conditions she was offering the child than the actual frequency. Before these proportions were used as the basis for analysis of variance, an arcsine transformation (Winer, 1962, p. 221) was performed.

The coding of all interviews was performed by the author after all identifying information relevant to the number of the interview and the condition were removed. The reliability of the coding for the seven categories and for the total score was assessed by recoding 10 randomly selected transcripts at least 6 weeks after the initial coding had been completed. The Pearson product-moment coefficients of correlation are reported in Table 7 and indicated that the intrarater agreement was generally satisfactory.

The ratings of the entire final interview provided a measure of therapist performance and was based on the scales developed by Rioch et al. (1963). Each dimension (see Appendix C) was rated on a 5-point scale ranging from Poor (1) to Excellent (5). The total score was the sum of the ratings for the nine items. A rating of the patient's accessibility to therapy on a 5-point scale (Very Easy to Very Difficult as 1 to 5 points respectively) provided an additional basis for comparing the children assigned to the three conditions.

The ratings of the final interview were made by an experienced psychiatric social worker who is a member of the faculty of the Family Therapy Institute of Chicago and who has been engaged in the teaching and supervision of psychotherapy for 14 years. The rater was unfamiliar with the purpose of the project and the nature of the therapists involved although she was aware that some of the therapists were in training. She received the typed transcripts of the final session with all identifying information removed except for the child's age. The order in which the transcripts were rated was random with respect to condition.

Interrater agreement was investigated by having the rater rerate 10 randomly selected transcripts at least 6 months after the initial rating. The correlations (rs) for the 9 scales and the total score are shown in Table 7.

Table 7

Intrarater Agreement for Ratings of the Final Interview and the Process Variables

Final Interviews	r	Process Variables	r
Global	.58	Reflection	.87
Respect	.56	Conversation	.94
Interest	.74	Personal Info.	.95
Understanding	.83	Directing	.86
Affect	.14	Pos. Comments	.96
Beginning Interview	.60	Neg. Comments	.76
End Interview	.74	Miscellaneous	.95
Prof. Attitudes	.54	Total Responses	.95
Use of Cues	.72		
Total	.67		
Pt. Difficulty	.84		

Procedure

The study may be conceptualized in terms of three phases: (1) pretherapy-- evaluation of children and students and training of students; (2) therapy; (3) posttherapy--evaluation of children and students in the period following the completion of therapy.

All aspects of the project (testing, training, interviewing, and therapy) were carried out at the Guidance Center with the exception of the pretests and posttests for nine students in the control condition. They were tested in their classroom at Loyola University. Table 8 provides a summary of the measures obtained from the various groups of subjects and the times at which they were obtained.

Pretherapy. One-half of the student subjects were recruited and trained each semester during the first year of the project. As noted previously, all students were volunteers who were informed of the possibility of participating in the project through talks given by the investigators in education classes or at special meetings which had been announced in class. During the recruiting sessions, all students who were interested in participating completed a questionnaire which provided their telephone numbers and information about their education and experience (i.e., year in school, grade-point average, number of courses in psychology and education, and experience or knowledge relevant to psychotherapy). An appointment for taking the pretest was then arranged by telephone for those who were willing, had a satisfactory grade-point average (C or 3.0), and no background in psychotherapy. At the time of the pretest, the students provided information about their schedule of classes and other commitments. These schedules were then used in assigning students to the experimental and placebo conditions and in scheduling the training sessions. During each semester seven students were assigned to each of the conditions. Students who could not be assigned to one of the conditions because their available time did not coincide with that of the other students and trainers were assigned to the control condition (pretest and posttest only). They were told that they might have an opportunity to participate in a later training group.

The training for subjects in the experimental and placebo conditions was similar in that all trainees received eight training sessions. The sessions were scheduled on a semi-weekly basis and each lasted for approximately 1½ hours. The format of the sessions was kept as similar as possible for the two groups but the content varied. Students in the experimental condition received training in nondirective play therapy from an experienced child psychologist and the co-investigator (PB). "Training" for the students in the placebo condition emphasized being friendly and was provided by the author (JF) who had had no direct experience in doing therapy with children. Although the possibility of briefer training was considered for

Table 8

Measures Obtained During Three Phases of Study

Subjects	Pretherapy (or Pretraining) and Posttherapy	Therapy
Students	Minnesota Teacher Attitude Inventory	Process Ratings
	Michigan Picture Test	Ratings of Final In Interview
	Incomplete Sentences Blank	
Esperienced Therapists	(No Measure)	(Same as Students)
Children	Target Complaints (M,F,T)[1]	
	Incomplete Sentences Blank (C)	
	Semantic Differential (M,F,T)	

[1] M = Mother, F = Father, T = Teacher, C = Child

students in the placebo condition, this seemed unwise because it appeared desirable to have the students in this group believe that they had received training in an effective approach.

Several aspects of the training for both groups were the same. Each group was informed during the first training session that there was another training group in which some of their friends might be participating and the importance of not communicating with students in the other group was emphasized. The trainer explained that two somewhat different methods were being employed by the two groups and that sharing experiences or comparing notes with the other group would make the two groups more similar and would invalidate the research designed to compare the two approaches. It was suggested that both approaches appeared to be beneficial and that the purpose of the present investigation was to gain more information on each. This limitation on discussion seemed to be well accepted and there was no reason to suppose that the students in the two conditions did discuss their experiences with one another.

Sessions 3 through 7 for each group were devoted to practicing their respective roles with a normal child (sons of faculty members). During these sessions the students took turns being the "therapist" while the trainer and the remaining students observed through a one-way mirror. This approach enabled each student to have four or five practice sessions. This procedure, in addition to helping the students to become familiar with boys the ages of their clients and the play materials, seemed to be beneficial in reducing anxiety about being observed and recorded on tape.

Session 8 was devoted to the assignment of patients, the review of case materials, and the further discussion of Guidance Center policy. The concerns about policy included: confidentiality, fees (set by the Guidance Center and not a concern of the therapist), obligations to the patients (being on time, having room ready, etc.), communications about cancellations, and the writing of progress notes after each session. The students were told that parents' questions should be referred to one of the trainers who would be available during the play interviews and, in addition, that any potentially serious behavior on the part of the child should be reported to the trainer at the end of the session. Such behaviors included talk about suicide or fire-setting, danger of being expelled from school, or bad fights. Finally, each student was reminded to tell her client that she would be seeing him 12 times so that he would anticipate the time-limited nature of the contact. Each student then called the parent and arranged the times for the weekly play interviews. All students were urged to discuss any problems or uncertainties that might arise during the interviews with one of the trainers. The content specific to the two training approaches is presented below.

Experimental Group. Session 1: All trainees were introduced to each other and to the trainer. A short orientation to the history and goals of the Guidance Center was given; emphasis was placed on the Center as a place to obtain help with real problems. Questions about the Center and the clients who attend were encouraged and misconceptions were clarified as they were revealed in the question content.

Nondirective therapy was introduced through a discussion and elaboration of Axline's eight basic principles (Axline, 1947, pp. 75-76). Each principle was read, restated in behavioral terms, and examples of application discussed. Questions were encouraged and participation by the trainees in "what if" speculation was fostered. The trainer used every opportunity to define therapy as a particular relationship with particular goals; the differences between the therapeutic relationship and other adult-child relationships were noted as appropriate materials arose.

Session 2: All trainees had been asked to read Dibs in search of self (Axline, 1964) between the first and second sessions. The whole session was devoted to a discussion of Dibs. Discussion focused on the relationship of the case material to the eight basic principles; several examples of each principle were elicited from the trainees and many more "what if" hypothetical management situations were discussed. The trainer continued to emphasize the special nature of the therapeutic relationship and to directly encourage adherence to the principles as the correct way of thinking about and responding to behavior in the therapeutic situation.

Sessions 3 through 7: Each of the next five sessions was devoted to practicing nondirective therapeutic behavior in relationship to a volunteer "client." During the observation the trainer noted particular behaviors of the trainee or client and offered suggestions as to alternative responses. The commentary was essentially positive and supportive with the intent of improving responses by developing confidence and reducing anxiety about participation in the therapeutic situation.

Several different child clients were used in this training experience. The children were told that they could help the trainees learn to play with boys by playing as they would like to during the period. During one session a boy who had "played" on several occasions was instructed to play the role of a "bad boy in his classroom"; he produced a very convincing display of provocative, negativistic behavior which tested the composure of several trainees and provided significant discussion material regarding appropriate responses to provocation and limit-breaking behavior.

Session 8: In addition to the material described previously for both groups, this session included each trainee's sharing of her ideas about problems she anticipated with her client on the basis of the available case materials. Discussion of how such problems might be responded to ensued. Apprehension about actual involvement in treatment was revealed by the number and severity of the problems anticipated; the trainer responded with expressions of confidence in the ability and poise of the trainees.

Placebo Group. Session1: This session provided an introduction to the Guidance Center and the new program in which each student would have 12 play sessions with an emotionally disturbed boy. The necessity of confidentiality with respect to material produced in the play sessions and the patients was discussed.

The major focus of this session was on the role of the therapist and discussion centered on the importance of friendship for the boys they would be seeing and the beneficial effects of play. The students were encouraged to think of their role as that of a responsible adult friend--perhaps similar to an aunt or godmother. The characteristics of a friendly relationship were elaborated through the students' ideas of what was involved in being a friend, e.g., listening, providing support and encouragement, giving advice and suggestions, trying to understand problems, and cheering up the other person. The importance of play was discussed in terms of Erikson's (1963) autotherapeutic uses of play and the students were given an excerpt from Childhood and Society (pp. 222-232) to read before the next session. This excerpt was carefully selected to illustrate the possibility that play can be important to the child in working out a problem without providing insight into the ways the experienced therapist may use this information.

Session 2: This was devoted to familiarizing the students with the playrooms, the play materials, and the occasional necessity for setting limits. The material relevant to establishing limits was based on Ginott (1961, pp. 101-123). However, the trainer emphasized the clear statement of the limits for several behaviors (i.e., child not hurting himself, the therapist, or damaging the playroom). No feelings or wishes or helping him to express the feelings of resentment which are likely to arise when limits are invoked. In other words, the students received information on the setting of limits (when and how) without being told about more insightful or therapeutic ways of handling the situation.

Sessions 3 through 7: These were devoted to role playing the "friend" role with a normal child. Following the practice sessions on each day, the student role-players and the observers discussed what occurred during the play periods and presented ideas about how each had performed her role. The emphasis throughout was on the friendship

role and the trainer avoided making comments which might provide background on the basic approaches of nondirective play therapy, such as reflection and clarification of feeling and actions. Questions about how to handle particular behaviors were referred to the group for discussion and ideas on management.

Session 8: This session was devoted to the material described previously and to reassurance that the many problems envisioned by the students would probably not occur.

During the period of student selection and training , the child subjects were recruited and their parents were seen by one member of the staff of the Guidance Center for interviews and testing relevant to the project. The teachers' ratings were also obtained at this time.

Therapy. Under all conditions (except the control) there were 12 sessions of play therapy, each approximately 50 minutes in length. Sessions were scheduled on a once-per-week basis in one of two play-rooms equipped with one-way mirrors. An adjacent room provided facilities for observers and equipment for making tape recordings of the sessions. Four play sessions (1, 4, 8, and 12) were observed and tape recorded for all subjects. In several instances where the tape recorder failed to work properly, the next session was substituted, i.e., session 2 for session 1, etc.

In addition to the observations and tape recordings obtained for the purpose of later analysis, the trainers (PB or JF) observed each student during part of the first interview and during occasional later interviews to be sure that the student was able to handle the child and that the child was not too disturbed to be seen in this manner.

In addition to the observations by the trainers, each student summarized what happened during each interview and reported her impressions of what went on immediately following each session. These summaries were reviewed by the trainers and a supervisory session to discuss problems was scheduled if it appeared necessary. Such sessions were seldom scheduled, however, since one of the trainers was always available while the students were conducting their interviews, and there were frequent informal discussions of the interviews immediately following the child's departure. Questions of how to handle particular behaviors were handled in a manner consonant with the student's prior training (placebo or experimental condition). Prior to the ninth interview, each student was instructed to remind her client that he would have only three more interviews with her but that he might, if he and his parents agreed, continue to come to the Guidance Center.

With the exception of the trainers' infrequent, brief contact with the parents when they had a particular question, parents were not seen between the pretherapy and posttherapy interviews. Although this approach was contrary to the usual practice of the Guidance Center, it seemed important to limit contact with the parents to avoid the possibility that improvement in the child might be attributable to work with the parents rather than to the play interviews.

Posttherapy. Following the twelfth interview, the pretherapy measures were repeated for all groups (students, children, parents, and teachers). For subjects in the control conditions, the pretherapy measures were repeated after an interval which was comparable to the treatment period for subjects in the experimental, placebo, and experienced-therapist conditions. Parents of children who had participated in the play interviews were told that the posttherapy evaluation was important in determining the child's progress to date and in making further recommendations. To avoid the possibility that parents might feel that indicating improvement (e.g., on the Target Complaints) might jeopardize their child's opportunities for continuing in therapy, they were told that they should present their current impressions as accurately as possible and that indications of improvement would not preclude additional treatment if that seemed desirable.

The repetition of the pretherapy measures for children in the control condition was explained to the parents by noting that it was desirable to have a current picture of the child's status before he began therapy. Unless informed by the parents, the teachers were presumably unaware that children in the control condition had not been in therapy during the past three months.

Results

Measures of Outcome

The three measures of outcome (Target Complaints, Semantic Differential for Parents and Teachers, and the Incomplete Sentences Blank) were used in testing the hypothesis that evidences of improvement for children in the four conditions ranged from most to least in this order: experienced-therapist, experimental, placebo, and control.

In addition, the pretherapy measures for each of these variables provided a basis for further evaluating the comparability of the children assigned to the four conditions. Finally, the relationships among the respondents and among the measures of outcome were considered in order to investigate the reliability and validity of the present measures. The intercorrelations between the scores obtained from mothers, fathers, and teachers provided the basis for examining test-retest reliability and agreement between respondents on the Semantic Differential and on Target Complaints. The change scores for the three measures were intercorrelated to evaluate the degree to which these approaches were associated in providing evidence of change in children's behavior or adjustment.

Target Complaints. The pretherapy aspect of this measure required that each mother, father, and teacher present the problems with which he would like to see the child helped during therapy. Mothers and fathers then rated the severity of each problem of a 13-point scale on which higher ratings indicated greater severity. Table 9 shows the means and standard deviations for the number and severity of the complaints presented independently by each type of respondent for the children in each condition.

The scores for each group of respondents for number and severity were subjected to a one-way analysis of variance to investigate differences between the children assigned to the four conditions. The F values (Table 9) for number of problems as reported by mothers, fathers, and teachers were not significant (F = 1.59, 1.55, and .14 respectively). Similarly, the analyses of variance for mean severity indicated no significant differences between conditions for mothers (F = .92) or fathers (F = .57). It may be noted that the mean number of problems presented by the various groups ranged from 1.19 to 3.71 and the mean severity of the problems ranged from 8.08 to 9.66, i.e., between Pretty Much a Problem (7 pts.) and Very Much a Problem (10 pts.). With one exception, fathers tended to present slightly fewer problems than mothers and to rate them as somewhat less severe.

The posttherapy evaluation of change for the complaints presented previously was based on the mean of the change ratings for

Table 9

Target Complaints: Descriptive Statistics and F Values

Condition[1]		Pretherapy Severity Mo.	Pretherapy Severity Fa.	Pretherapy Number Mo.	Pretherapy Number Fa.	Pretherapy Number Teach.	Posttherapy Change Mo.	Posttherapy Change Fa.	Posttherapy Change Mo. & Fa.	Posttherapy Change Teacher
Experienced - Therapist (ET)	M	9.66	8.09	2.55	1.91	3.00	5.01	5.03	5.02	3.83
	SD	2.14	1.69	1.29	0.83	1.26	.79	1.11	.78	1.53
Experimental (E)	M	9.45	8.39	3.71	3.00	3.15	5.04	5.25	5.15	5.02
	SD	1.25	1.32	1.77	1.50	.80	1.12	0.99	1.01	1.48
Placebo (P)	M	9.00	8.85	3.67	2.58	3.00	4.72	4.62	4.69	4.84
	SD	1.57	1.65	1.87	1.24	.50	.91	.71	.75	1.41
Control (C)	M	8.65	8.75	2.91	2.64	2.17	4.23	4.11	4.17	4.07
	SD	1.40	1.60	1.14	1.28	.98	.30	1.20	.69	1.15
F		< 1.0	< 1.0	1.59	1.55	< 1.0	2.37	2.94	3.19	1.42
p		NS	NS	NS	NS	NS	< .10	< .05	< .05	NS

[1] N for conditions and respondents:

ET: Mo. Fa. = 11, T = 5
E: Mo. Fa. = 14, T = 13
P: Mo. Fa. = 12, T = 11
C: Mo. Fa. = 11, T = 7

each respondent (Table 9). The 7-pt. scale for rating change ranged from Much Worse (1) to Much Better (7) with No Change as the midpoint (4). With respect to the hypothesized evidences of change for the four conditions, the means for mothers' and fathers' ratings of change indicated similar levels of improvement for children in the experienced-therapist and the experimental conditions. For teachers, the difference between the two groups was more pronounced with the children in the experimental condition showing slight improvement ($M = 5.02$) while those in the experienced-therapist condition were slightly worse ($M = 3.83$). With this exception, the mean change scores supported the hypothesis that improvement would be greater for the experimental group than for the placebo group and both would show greater improvement than the control group.

One-way analyses of variance were used to investigate the significance of differences between the four conditions where the change scores for each type of respondent were considered separately. As indicated in Table 9, the difference between conditions was significant for fathers ($F = 2.94$, $p < .05$), approached significance for mothers ($F = 2.37$, $p < .10$), and was significant for the combined ratings of change based on the means for both parents ($F = 3.19$, $p < .05$. The obtained F of 1.42 for teachers was not significant.

Duncan's Multiple-Range Test was used to test the significance of the differences between all possible pairs of means based on parents' scores for the four conditions. The obtained F values indicated that the means for both the experienced-therapist and the experimental conditions were significantly higher ($p < .05$) than the means for the control condition as reported by mothers, fathers, and for their combined ratings. None of the differences between the placebo condition and other conditions was significant.

In the preceding analyses the score for each respondent was the mean of the changes reported by him for all problems which had been mentioned in the pretherapy interview. Although it might be anticipated that the ratings of change for the individual problems would reflect differences between the treatment conditions similar to those obtained for the mean change ratings, outcome in terms of the individual problems was also examined. Table 10 shows the frequency with which the problems were rated as Worse, No Change, or Improved following therapy. Since the number of complaints reported by the various types of respondents varied considerably, the percentage of problems characterized as Worse, etc. is also provided. Although statistical analyses of these data were not possible because the ratings of the problems were not independent, the general trends may be noted.

In line with the previous findings, the percentage of the problems rated Improved for the four conditions was highest for the experienced

Table 10

Target Complaints: Frequency of Problems Rated as Improved, No Change, and Worse

Condition	Rating of Problem: Worse N	Worse %	No Change N	No Change %	Improved N	Improved %	Total Problems
Experienced							
Mother	1	3.57	11	39.29	16	57.14	28
Father	1	4.76	7	33.33	13	61.90	21
Teacher	3	20.00	6	40.00	6	40.00	15
Total	5	7.69	24	36.92	35	53.85	64
Experimental							
Mother	3	5.77	17	32.69	32	61.54	52
Father	0	0.00	17	41.46	24	58.54	41
Teacher	3	7.32	10	24.39	28	68.29	41
Total	6	4.47	44	32.84	84	62.69	134
Placebo							
Mother	7	15.91	13	29.55	24	54.55	44
Father	3	9.68	14	45.16	14	45.16	31
Teacher	5	15.15	8	24.24	20	60.61	33
Total	15	13.89	35	32.41	58	53.70	108
Control							
Mother	0	0.00	23	71.88	9	28.12	32
Father	3	10.34	17	58.62	9	31.03	29
Teacher	4	25.00	4	25.00	8	50.00	16
Total	7	9.09	44	57.14	26	33.77	77

therapist and experimental conditions, intermediate for the placebo condition, and lowest for the control condition. The percentage of problems viewed as unchanged reversed this trend with the highest percentages of No Change reported for children in the control condition. The possibility that positive changes may be accompanied by significant evidence of deterioration for treated patients, as suggested by the study of Carkhuff and Truax (1965a), was examined in terms of the percentage of problems considered to be worse. It may be noted that the percentages were generally quite low for mothers and fathers regardless of the condition to which the child had been assigned. For teachers' ratings, however, the frequency with which the problems were judged to be worse was generally higher than that for the parents with the exception of children in the experimental condition. The reason for the somewhat higher percentage of deterioration reported by teachers is not apparent. The ratings may reflect a difference in the type of problems which the respondent wished im proved and further that positive changes were less often obtained in the school situation. In any event, the data from Target Complaints did not indicate that the overall incidence of deterioration was a matter for concern in either the experienced therapist or the experimental condition.

Semantic Differential for Parents and Teachers. The total scores and the factor scores for the actual measures (Total Actual score) obtained in the pretherapy and posttherapy periods provided the most basic data relevant to outcome for this measure. Specifically, higher scores on the posttherapy measure (in contrast to the pretherapy measure) suggest that the respondent perceived positive changes in the child.

The scores for parents' standards or ideals for their child (Total Ideal Score) as measured in the pretherapy and posttherapy periods provided the basis for examining changes in parents' reports of how they would like their child to be.

The descriptive statistics for the Total Actual scores are presented in Table 11. The customary check on the comparability of the children assigned to the four conditions through one-way analyses of variance again indicated that the differences between the groups on the pretherapy measures were not significant (see Table 11).

In analyzing the Total Actual scores obtained in the pre- and posttherapy periods, an analysis of variance appropriate for a two-factor experiment with repeated measures on one factor (Winer, 1962) was performed for the scores obtained from each type of respondent and for the combined scores of mothers and fathers. The results of these analyses are reported in Table 12. These analyses revealed that none of the differences between the pre- and posttherapy measures was significant when the scores for mothers, fathers, and

Table 11

Semantic Differential: Descriptive Statistics for Pretherapy and Posttherapy Total Actual Scores

	Mother		Father		Mother & Father		Teacher	
Condition[1]	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Experienced (ET)								
M	258.64	260.45	271.73	272.73	531.27	533.18	236.20	239.20
SD	22.64	17.30	26.58	23.17	46.65	35.19	22.90	18.02
Experimental (E)								
M	253.79	270.14	257.92	272.42	511.42	544.92	236.14	244.00
SD	17.13	28.40	17.92	20.33	26.18	43.72	37.71	38.48
Placebo (P)								
M	258.27	262.55	259.08	262.92	523.27	526.73	234.09	239.18
SD	34.25	35.16	33.12	33.33	44.78	62.05	33.06	34.96
Control (C)								
M	252.36	261.73	254.91	254.45	507.08	516.00	21.00	233.00
SD	29.11	25.82	24.19	34.68	46.97	57.10	12.25	31.04
F	< 1.0		< 1.0				1.0	

[1] N for conditions and respondents: ET: Mo., Fa. = 11, T = 5
E: Mo. = 14, F. = 12, T = 14
P: Mo. = 11, F. = 12, T = 11
C: Mo., Fa. = 11, T = 7

Table 12

Semantic Differential: Analyses of Variance for Total Actual Scores for Mothers, Fathers, and Teachers

	Mother			Father			Mother & Father			Teachers		
Source of Variation	df	MS	F	df	MS	F	df	MS	F	df	MS	F
Between Subjects	46			45			44			36		
A (Conditions)	3	98.45	< 1.0	3	1247.74	< 1.0	3	1812.37	< 1.0	3	194.38	< 1.0
Subjects w. groups	43	833.33		42	1432.95		41	4142.92		33	2209.18	
Within Subjects	47			46			45			38		
B (Measures)	1	1471.18	1.60	1	512.17	2.54	1	3182.26	5.56*	1	318.94	< 1.0
A x B	3	239.81	< 1.0	3	109.35	< 1.0	3	1188.24	2.07	3	13.91	< 1.0
B x Subjects w. groups	43	922.18		42	201.66		41	571.92		34	337.85	

*p .025

teachers were analyzed separately. However, when the scores of the parents were combined the main effect for measures was significant ($F = 5.56$, $p < .025$). None of the main effects for conditions or for the interaction between measures and conditions was significant. The absence of significant differences between the subjects in the various conditions was further confirmed by analysis of covariance.

The significant effect for measures reflected the fact that the means for the posttherapy scores were higher than those obtained in the pretherapy period. Previously planned orthogonal comparisons between the pre- and posttherapy measures by means of t tests for related measures were used to investigate the differences between the measures for each condition. The results of these comparisons for the combined mother and father Total Actual scores indicated that only the children in the experimental condition showed significant improvement ($t = 3.32$, $p < .01$ by two-tailed test). It may be noted that this represented a mean change of 33.50 points. Similarly large increases in the Total Actual scores were also noted between the pre- and posttherapy measures for mothers and fathers considered separately. The differences for the children in the experimental condition were significant in both instances (mothers: $t = 2.24$, $p < .05$; father: $t = 4.16$, $p < .001$). However, since the analyses of variance did not indicate significant effects for measures, it is possible that the differences indicated by the obtained ts are not reliable.

In summary, the findings relevant to outcome based on the Total Actual scores were similar to those obtained for the Target Complaints with respect to the experimental, placebo, and control conditions. The comparison of the groups in terms of evidences of improvement (higher mean scores on the posttherapy measures) indicated that the ordering of the means was partially as hypothesized with the children in experimental condition showing the most marked (and sometimes significant) evidence of improvement and children in the placebo condition generally showing changes intermediate between those for the experimental and control conditions. The single exception involved mothers' scores which indicated that improvement was greater for the control condition (M difference = 9.37) than for the placebo condition (M difference = 4.28). However evidence of positive change for children in the experienced therapist condition was substantially lacking in that the differences between the pre- and posttherapy measures were consistently small (always less than those for the placebo condition and generally less than those for the control condition).

The factor scores for the Semantic Differential were obtained to investigate the possibility that subpatterns of scores (as defined by the factors) might provide more information on general areas in which the child was high or low and especially the areas which evidenced change following therapy. The means and standard deviations for the four factor scores for mothers, fathers, and teachers are reported

in Tables 13 through 15. In each instance, the obtained score for each respondent on each factor was multiplied by 100 and 100 was added to the score so that negative scores were eliminated. Although the probability that the factor scores were correlated suggested that a multivariate analysis would be the approach of choice, it appeared that the initial examination of change between the pre- and posttherapy factor scores might be accomplished more simply through the use of t tests for related measures. The results of these analyses are presented in Table 16. In these comparisons (Table 16), the evidences of change, and particularly improvement on the posttest, were of interest for the experimental group since the subjects in this condition had been characterized by significant changes in terms of the Total Actual scores. Two of the 12 comparisons for children in this condition were significant. Fathers' Factor I scores ($t = 3.26$, $p < .01$) indicated a shift in the direction of Relaxed-Nonaggressive (in contrast to Nervous-Aggressive). Mothers' scores for Factor IV ($t = 3.13$, $p < .01$) indicated a shift toward greater Dominance (in contrast to Submission). The encouragement provided by this finding was dissipated by similar findings for children in the control condition where the differences were only slightly less significant ($p < .05$). In addition, the fact that only 4 of the 48 comparisons were significant suggested the possibility that the obtained differences might be accounted for largely on the basis of chance.

The second major area of interest for the Semantic Differential involved the measurement of parents' ideals for their children in the pre- and posttherapy periods. As noted previously, this interest was created by Hobbs' (1966) report that children who had participated in Project Re-ED were perceived by their parents as improved on the basis of a semantic differential similar to the one used in the present study. In addition, he noted that fathers in particular tended to lower their standards for the children (presumably in conjunction with improvement) while mothers more frequently raised their standards. These findings suggested three questions which might be further investigated on the basis of the present data for the ideal scores: (1) Do parents tend to lower their ideal for their child? (2) Is this change more pronounced for fathers than for mothers? (3) If the downward shift occurs, what variables are associated with the shift?

Table 17 shows the means and standard deviations for the Total Ideal scores obtained in the pre- and posttherapy periods. As with the other measures, the F values for the pretest measures were not significant. The analyses of variance for repeated measures based on the scores for mothers, fathers, and the combined scores of both parents are reported in Table 18. Similar to the findings for the Total Actual scores, the analyses for mothers and fathers considered separately yielded no significant main effect for measures. However, the main effect for measures based on the combined scores of the parents was significant ($F = 4.14$, $p < .01$). The main effect for

Table 13

Semantic Differential: Descriptive Statistics for Pre- and Posttherapy Factor Scores for Mothers

	Factor							
	I		II		III		IV	
Condition	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Experienced T. (N = 11)								
M	97.61	99.58	94.55	92.04	95.54	95.02	92.57	92.01
SD	14.21	12.02	8.98	7.26	16.22	12.93	15.14	13.44
Experimental (N = 14)								
M	97.26	98.47	102.44	97.57	89.43	95.34	88.02	94.26
SD	15.22	13.62	15.28	11.17	16.36	12.41	10.10	9.05
Placebo (N = 12)								
M	96.65	99.16	91.02	94.08	96.10	97.50	91.10	91.65
SD	15.67	12.76	15.92	11.03	17.60	20.30	14.58	12.26
Control (N = 11)								
M	101.95	101.17	88.85	87.30	99.18	94.95	86.81	90.48
SD	16.54	12.42	13.82	10.08	17.95	17.58	16.94	13.47

Table 14

Semantic Differential: Descriptive Statistics for Pre- and Posttherapy Factor Scores for Fathers

Condition		Factor I		Factor II		Factor III		Factor IV	
		Pre	Post	Pre	Post	Pre	Post	Pre	Post
Experienced T (N = 11)									
	M	94.09	92.90	97.47	101.89	92.17	91.38	96.68	98.25
	SD	15.14	15.41	19.22	13.40	15.01	10.79	19.51	9.97
Experimental (N = 12)									
	M	85.17	91.67	93.70	97.94	96.77	99.07	89.44	94.98
	SD	11.63	8.59	17.46	13.37	16.25	10.42	12.82	11.63
Placebo (N = 12)									
	M	93.87	93.39	96.53	92.26	87.93	91.35	90.45	90.50
	SD	16.80	15.00	13.75	12.64	15.36	11.41	17.22	16.34
Control (N = 11)									
	M	83.88	88.32	103.05	105.06	96.14	91.67	89.20	87.94
	SD	11.30	10.00	19.13	13.57	12.88	8.92	17.29	20.98

Table 15

Semantic Differential: Descriptive Statistics for Pre- and Posttherapy Factor Scores for Teachers

	Factor							
	I		II		III		IV	
Condition	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Experienced T. (N = 5)								
M	96.30	98.60	103.20	103.94	101.20	100.60	97.00	96.87
SD	14.21	14.18	13.38	10.19	9.52	7.65	17.18	15.81
Experimental (N = 14)								
M	95.26	96.92	96.42	100.21	104.79	106.31	104.26	103.97
SD	14.56	14.42	16.04	13.80	15.16	16.05	13.90	14.98
Placebo (N = 11)								
M	107.20	102.76	101.87	102.42	92.40	93.47	92.29	97.23
SD	15.19	11.55	13.94	12.67	13.14	15.09	10.05	10.24
Control (N = 7)								
M	95.15	94.15	102.57	101.46	103.00	103.83	92.86	98.33
SD	14.96	12.06	11.96	7.82	13.53	9.54	16.91	15.39

Table 16

Semantic Differential: *t* Values for Differences Between Pre- and Posttherapy Factor Scores for All Respondents

Condition[1]	Factor I			Factor II			Factor III			Factor IV		
	M	F	T	M	F	T	M	F	T	M	F	T
Experienced T. *t*[2]	1.35	- .51	.47	-1.32	1.38	.14	- .19	- .13	.17	- .21	.35	.00
Experimental *t*	.67	3.26**	.91	-2.15	1.20	1.15	1.37	.57	.26	3.13**	1.34	- .23
Placebo *t*	.39	- .12	-1.96	.57	- .30	.19	.02	1.82	.24	1.19	.02	1.83
Control *t*	- .22	2.97*	- .45	- .63	.79	- .54	-1.82	-1.48	.27	2.26*	- .44	2.37

[1] *N* for groups same as Tables 13, 14, & 15

[2] Negative *t* value represents lower score on posttest.

* $p < .05$ (for two-tailed test)
** $p < .01$ (for two-tailed test)

Table 17

Semantic Differential: Descriptive Statistics for Total Ideal Scores for Pre- and Posttherapy Measures

	Mother		Father		Mother & Father	
Condition	Pre	Post	Pre	Post	Pre	Post
Experienced T.						
M	334.00	316.09	335.00	325.00	669.09	641.09
SD	20.39	30.42	24.07	29.56	32.93	54.32
Experimental						
M	337.93	326.71	326.08	315.92	663.33	644.92
SD	12.76	16.65	14.45	14.73	22.71	20.52
Placebo						
M	323.64	316.27	342.50	335.58	664.73	650.36
SD	14.96	19.58	17.93	23.10	25.24	32.82
Control						
M	336.91	335.91	315.55	331.18	661.10	661.00
SD	14.68	10.56	38.28	21.59	31.13	19.93
F	1.81		2.24			
P	NS		<.10			

Table 18

Semantic Differential: Analysis of Variance for Total Ideal Scores for Pre- and Posttherapy Measures

	Mother			Father			Mother + Father		
Source of Variation	df	MS	F	df	MS	F	df	MS	F
Between Subjects	46			45			43		
A (Conditions)	3	1254.20	1.74	3	1500.40	1.63	3	140.21	<1.0
Subjects w. groups	43	722.20		42	920.87		40	1027.72	
Within Subjects	47			46			44		
B (Measures)	1	2053.74	1.38	1	183.32	<1.0	1	4871.39	4.14*
A X B	3	294.50	<1.00	3	686.14	2.08	3	804.61	<1.0
B X Subjects w. groups	43	1487.06		42	330.56		40	1176.10	

*$p < .05$

conditions and the interaction between measures and conditions were not significant in any of the analyses.

Further investigation of the differences between the measures for children in the four conditions through t tests for related measures suggested that the significant lowering of the ideal scores on the posttest was most pronounced for children who had participated in the play interviews. Thus the difference between the two measures for the control group was negligible (pretest $\bar{M}$ = 661.10; posttest $\bar{M}$ = 661.00) while the differences between the means for the pre- and posttherapy measures for children in the experimental and placebo conditions were significant for the parents' combined scores (t = 2.49 and 2.51 respectively; $p < .05$). Although the difference between the means for the children in the experienced therapist condition was not significant (t = 1.66) the difference between the pre- and posttherapy measures was larger than that obtained for the other conditions and suggested a trend in the same direction.

In answering the questions raised previously, there was some evidence that parents did tend to lower their ideals for their children and that this tendency was similar for mothers and fathers. While the changes for mothers and fathers considered separately were not significant, the evidence provided by the analyses of their combined Total Ideal scores indicated that the downward shift occurred in relation to the child receiving therapy. Although it had seemed possible that the lowering of the ideal was related to perceived improvement in the child, this relationship was not supported in terms of changes in the Total Actual scores or Target Complaints. The relationship between Actual Change and Ideal Change scores (i.e., the difference between the pretest and posttest in each instance) was investigated through correlations between the parents' scores. The correlations for mothers and fathers were .26 and .29 respectively ($p < .10$) and indicated that there was a tendency for improvement in terms of Actual scores to be associated with higher posttherapy scores on the ideal. The correlations between Ideal Change and Target Complaints (see Table 22) were consistently low (r = -.05 for mothers and -.12 for fathers) as were those for change on Sentence Completion (r = .01 and -.21 for mothers and fathers respectively).

Incomplete Sentences. The descriptive statistics for this measure are reported in Table 19. The means for the children in the four conditions on the pretherapy measure were very similar and the lack of significant differences between the groups was supported by the results of the one-way analysis of variance (F = .84).

In addition, there was little evidence of improvement (as represented by lower scores) for any of the groups in terms of changes between the pre- and posttherapy administrations of the test. The

Table 19

Incomplete Sentences: Descriptive Statistics for Children

Condition		Pretherapy	Posttherapy
Experienced T. (N = 11)			
	M	128.27	130.64
	SD	7.94	16.70
Experimental (N = 14)			
	M	132.86	128.76
	SD	8.71	10.85
Placebo (N = 11)			
	M	130.67	125.73
	SD	12.64	10.43
Control (N = 11)			
	M	127.18	129.73
	SD	8.91	9.36
	F	<1.0	
	df	3,43	

analysis of variance for repeated measures (Table 20) revealed no significant differences for either of the main effects or the interaction. Consequently, the hypothesized improvement for the various groups receiving treatment and their superiority over the control group received no support.

Intrajudge and Interjudge Relationships for the Measures of Outcome. The first consideration involved the test-retest reliability of the parents and teachers' scores for the Semantic Differential and for children's scores for the Incomplete Sentences. The Pearson produce-moment correlations (rs) for the Semantic Differential scores were consistently quite high and significant ($p < .001$). For the Total Actual scores the correlations between the pre- and posttherapy measures were .62 for mothers, .75 for fathers and .71 for teachers. The correlations for the Total Ideal scores were .73 for mothers and .59 for fathers. The test-retest correlation for Incomplete Sentences was considerably lower ($r = .34$, $p < .02$).

The extent to which mothers, fathers, and teachers were similar in their reporting of children on the Semantic Differential and Target Complaints was investigated by obtaining the correlations between the scores for all possible pairs of respondents. The results (Table 21) suggested that interjudge agreement on the pretherapy measures was generally low with only the correlation between mothers and fathers for Total Actual scores significant ($r = .32$, $p < .05$). The correlations for the posttherapy scores indicated that agreement between mothers and fathers was generally higher than on the pretest and especially satisfactory in terms of Total Actual scores for the Semantic Differential ($r = 58$) and for the change scores for mothers and teachers and between those for fathers and teachers were consistently low regardless of the time of the measure.

Finally, intrajudge agreement in terms of the change scores for parents and teachers was investigated for the Semantic Differential and Target Complaints as well as adult-child agreement on the Incomplete Sentences. The obtained correlations (Table 22) indicated that the relationship between Actual Change (difference between the pre- and posttherapy measures) and the Change scores on the Target Complaints was significant for fathers ($r = .55$, $p < .001$), approached significance for mothers ($r = .26$, $p < .10$), and was significant for teachers ($r = .44$, $p < .01$). The correlations between Ideal Change and Target Complaints were low for both parents as were the majority of the correlations between the parent and child measures of change. The only significant adult-child relationship was obtained between the Actual Change scores for mothers and the Incomplete Sentences scores for children ($r = .40$, $p < .01$). Consequently, it is apparent that the change scores based on the three measures of outcome were, in general, not highly related. With the possible exception of the relationship between Actual Change on the Semantic Differential and

Table 20

Incomplete Sentences: Analysis of Variance for

Pre- and Posttherapy Measures

Source of Variation	SS	df	MS	F	p
Between Subjects		46			
A (Conditions)	155.81	3	51.94	< 1.0	
Subjects w. groups	7183.79	45	159.40		
Within Subjects		48			
B (Measures)	24.73	1	24.73	< 1.0	
A B	261.25	3	87.03	1.14	NS
B x Subjects w. groups	3367.56	44	76.53		

Table 21

Correlations Between Mothers (M), Fathers (F), and Teachers (T) for Scores on the Semantic Differential and Target Complaints

	Pretherapy			Posttherapy		
Measures	M-F	M-T	F-T	M-F	M-T	F-T
Semantic Diff.						
Total Actual	.32*	.15	.04	.58***	.21	.08
Total Ideal	.12			.29*		
Target Comp.						
Severity	.25					
Change				.71***	.29	.27

* $p < .05$

*** $p < .01$

Table 22

Correlations Between Measures of Outcome (Change Scores)

	Target Complaints			Incomplete Sentences		
Measure	M-M	F-F	T-T	M-C	F-C	T-C
Semantic Diff.						
Actual change	.26	.55***	.44**	-.40**	.07	.00
Ideal change	-.05	-.12		-.01	.21	
Target Comp.				-.21	-.19	.22

** $p < .01$
*** $p < .001$

and Change on the Target Complaints, the correlations indicated that the measures were assessing different aspects of change (or were simply unreliable).

Play Interview Variables

Two approaches were used in assessing the behavior of the experienced and student therapists during the play interviews: (1) ratings of the final interview; (2) process ratings of therapists' verbalizations during the first, fourth, eighth, and twelfth interviews. Each approach was used in testing the hypothesis that evidence of satisfactory therapist performance ranged from most to least satisfactory for the experienced therapists, students in the experimental condition, and students in the placebo condition.

Ratings of the Final Interview. The means and standard deviations for the nine variables relevant to the therapists' behavior plus the total scores (sum of the separate ratings) are shown in Table 23. The 5-pt. scale used in rating each variable ranged from Poor (1) to Excellent (5). One additional variable, Patient's Accessibility to Therapy, was also rated in a 5-pt. scale ranging from Very Easy (1) to Very Difficult (5).

As with the previous comparisons among the children, the ratings of Patient Accessibility showed no evidence of differences between the clients in the three conditions ($F = .06$).

One-way analyses of variance were used to compare the ratings obtained by therapists in the three conditions in terms of scores on the nine scales and the composite. With the exception of the scale for Respect for Patient, all of the F values (Table 23) were significant or approached significance. Further examination of the differences between the groups by means of Duncan's Multiple-Range Test revealed that the means for the experienced therapists were significantly higher than the means for the therapists in the experimental and placebo conditions in all instances in which the analysis of variance obtained or approached significance. However, none of the differences between the means for the experimental and placebo groups was significant.

Thus the hypothesized superiority of the experienced therapists was confirmed but the the expectation that the performance of the experimental therapists would be better than that of the placebo therapists was not supported. In addition, it may be noted that the differences between the groups frequently suggested a slight superiority for the therapists in the placebo condition.

In terms of actual levels of performance, the means for the experienced therapists suggested that their performance in the nine areas under consideration ranged from 2.14 to 4.18 or from Passable to Good. The mean ratings for the experimental and placebo therapists

Table 23

Ratings of Final Interview: Descriptive Statistics and F Values

	Condition							
	Experienced Therapist (N = 11)		Experimental (N = 14)		Placebo (N = 12)		F*	p
Variable	M	SD	M	SD	M	SD		
Global Impression	2.45	.82	1.36	.50	1.67	.65	8.92	<.01
Respect for Patient	3.82	.98	3.50	.94	3.04	1.01	1.85	NS
Interest in Patient	4.18	.75	2.93	.92	3.42	.67	7.68	<.01
Understanding of Patient	2.27	.82	1.00	.00	1.25	.31	25.27	<.001
Success Drawing Affect	2.14	.71	1.43	.62	1.87	.86	3.05	<.10
Beginning of Interview	2.45	.69	1.82	.61	1.96	.75	2.84	<.10
End of Interview	2.23	.65	1.50	.68	1.42	.67	5.15	<.05
Professional Attitude	3.14	1.14	1.93	.81	1.62	.64	9.56	<.01
Skill in Using Patient Cues	2.27	.90	1.07	.27	1.21	.40	15.89	<.001
Total	24.95	5.76	16.64	4.33	17.21	4.43	306.67	<.001
Patient Accessibility	2.77	.75	2.73	.66	2.67	.78	.06	NS

*df = 2,34

ranged from Poor to Satisfactory (1.00 to 3.50 and from 1.21 to 3.42 respectively). With the exception of the means for Respect for Patient and Interest in Patient, the student groups were characterized by generally low ratings (less than 2.00) indicating that performance was Poor or between Poor and Passable.

Process Ratings of Play Interviews. The verbal activities of the therapists in the three therapy conditions were investigated in terms of seven categories of verbalizations, i.e., Reflection and Clarification of Content and Feeling, Conversation, Seeking Personal Information, Directing and Orienting, Positive Comments, Negative Comments, and Miscellaneous (including Simple Recognition; Solicited Cooperation, Help, and Information; Seeking Impersonal Information; and Unclassified Responses). The process ratings obtained for the four play interviews (1, 4, 8, and 12) provided: (1) a basis for investigating the extent to which verbal activities of the student therapists indicated that they were conforming to the roles prescribed during the training sessions and (2) a basis for testing the hypothesis concerning satisfactory therapist performance. The original hypothesis was stated in general terms, but it may now be amplified with respect to the specific variables under consideration and expectations for therapist behavior in nondirective play therapy. It was hypothesized that the scores for Reflection and Clarification (including Reflective Structuring and Reflective Leads) are similar for the experienced therapists and students in the experimental condition and that the scores for both groups are significantly higher than those for students in the placebo condition. Conversely, Conversation is hypothesized to be significantly higher for the placebo condition than for therapists in the other two conditions. Similar hypotheses were formulated for Seeking Personal Information, Directing and Orienting Responses, and Positive and Negative Comments. That is, students in the placebo condition are expected to display significantly more of these behaviors which are not characteristic of the nondirective approach than the experienced therapists and students in the experimental condition. No specific hypothesis was formulated for the Miscellaneous category since it seemed that these responses might be anticipated with about equal frequency for all conditions.

Table 24 shows the mean number of responses coded in each category for each of the four interviews and the total (sum for interviews combined). The descriptive statistics for total verbalizations were based on the sum of the responses for all categories for the four interviews and included responses which were uncoded because of problems in hearing what the therapist said. Inspection of the means for these total verbalizations as well as those for the subcategories indicated that the placebo and the experienced therapist groups tended to be quite talkative and consistently made more responses (or initiated more) than the experimental group. These differences were confirmed by the significant F value obtained for total verbalizations considered

Table 24

Process Variables: Means, Standard Deviations, and Percentages for Play Interviews 1, 4, 8, and 12

Variable and Session		Experienced T (N = 11) M	SD	%	Experimental (N = 14) M	SD	%	Placebo (N = 12) M	SD	%
Reflection	1	38.91	17.00	29.87	23.31	16.16	55.97	9.00	6.01	8.01
	4	30.18	18.57	26.31	19.14	10.16	44.66	10.25	8.10	7.05
	8	28.20	22.31	25.45	16.00	13.04	34.51	7.17	6.24	5.81
	12	29.36	16.55	18.73	16.14	8.45	24.53	7.17	5.30	4.53
Total		124.09	62.27	25.09	75.00	37.82	39.92	33.58	21.04	6.35
Conversation	1	12.64	10.28	9.70	3.79	6.01	8.95	53.25	31.44	47.37
	4	22.18	17.21	19.33	5.00	8.77	11.67	83.50	52.05	57.46
	8	26.40	21.22	23.83	6.43	6.53	13.87	50.58	25.94	40.96
	12	22.45	17.94	20.10	19.79	19.54	30.08	72.83	44.56	45.89
Total		81.27	43.47	18.24	35.00	31.29	16.14	260.16	117.94	47.92
Perso. Info.	1	48.64	43.38	37.34	.36	.61	.85	1.75	3.94	1.56
	4	26.55	27.08	23.14	.29	.59	.68	1.42	1.85	.98
	8	24.70	22.94	22.29	.57	1.80	1.23	2.25	5.36	1.82
	12	23.55	17.95	21.10	.92	1.58	1.40	2.83	3.62	1.79
Total		121.18	89.79	25.97	2.14	2.47	1.04	8.25	7.60	1.54
Directing	1	7.18	9.45	5.51	1.71	3.06	4.04	13.17	8.07	11.71
	4	7.55	8.73	6.58	1.21	2.01	2.82	7.33	12.03	5.04
	8	6.00	6.13	5.42	2.14	3.83	4.62	17.16	16.79	13.89
	12	12.72	8.43	10.80	2.29	3.22	3.48	20.50	14.73	12.96
Total		33.45	21.66	7.08	7.36	9.68	3.74	58.17	42.18	10.90

Table 24 (Continued)

Variable ans Session		Experienced T			Experimental			Placebo		
Pos. Comments	1	4.00	3.46	3.07	.14	.35	.33	8.08	7.74	7.19
	4	4.64	4.27	4.04	.43	.73	1.00	7.66	7.32	5.27
	8	3.20	4.45	2.89	.57	.82	1.23	5.08	3.28	4.11
	12	3.82	4.41	3.20	.50	.73	.75	7.42	5.53	4.69
Total		14.45	9.32	3.30	1.64	1.44	.83	28.25	20.35	5.32
Neg. Comments	1	1.09	1.68	.84	.00	.00	.00	.25	.43	.22
	4	1.27	2.49	1.11	.14	.35	.33	1.66	3.04	1.14
	8	2.50	2.66	2.26	.93	1.53	2.01	4.83	7.64	3.91
	12	2.00	1.76	1.68	.79	1.90	1.20	4.17	4.90	2.64
Total		6.64	5.19	1.47	1.86	3.31	.89	10.92	10.81	1.98
Misc.	1	17.82	11.03	13.68	13.00	16.32	30.69	26.92	19.61	23.95
	4	22.36	13.08	19.49	16.64	13.71	38.82	33.33	17.43	22.93
	8	19.80	16.14	17.87	19.71	23.14	42.52	36.58	15.26	29.62
	12	25.36	21.19	21.20	23.36	18.51	35.50	43.25	21.76	27.25
Total		83.55	44.99	18.06	72.71	59.76	36.88	140.00	50.82	25.94
Total Responses	1	134.45	34.84		44.43	27.73		114.33	59.55	
	4	119.64	44.47		47.09	24.09		150.42	74.76	
	8	118.30	52.48		51.00	29.40		126.25	46.70	
	12	125.00	51.97		63.50	24.68		163.08	56.47	
Total		124.26	47.09		51.50	27.55		131.17	62.97	

over the four interviews (see Table 25). In addition, the large standard deviations indicated that there was considerable variability within groups. Because of these differences it seemed desirable to think in terms of the percentage of the total codable responses occurring in particular categories rather than relying on overall frequency.

In general, the percentages for a particular category for a particular group of therapists appeared to be fairly constant over interviews. It may be noted, however, that there was a tendency for Reflection and Clarification to decrease from the first to the twelfth interview for the therapists in all conditions. This tendency was especially marked for therapists in the experimental condition and appeared to be compensated for by an increase in Conversation and Miscellaneous Responses. For the experienced therapists there was also a decrease over time in Seeking Personal Information. The means and percentages for the placebo condition indicated that there was considerable consistency over interviews for all variables.

To test the hypotheses relevant to differences in performance between the conditions, a one-way analysis of variance was performed for each of the response categories. These analyses were based on the responses for all four interviews for each subject. Although a repeated-measures analysis was considered, it appeared that the one-way analysis would provide an adequate picture of the differences between the groups. In performing these analyses, the proportion of responses in a particular category were used after application of the arcsine transformation. The results of these analyses are reported in Table 25.

The obtained F values indicated that the therapists in the three conditions differed significantly on all variables. Further investigation of the differences between the conditions were based on Duncan's Multiple-Range Test (see Table 25). With respect to Reflection and Clarification, the hypothesis that the experienced and experimental group therapists are higher than the placebo group was confirmed ($p < .01$ in each instance). In addition, the experimental group scored significantly higher than the experienced therapists ($p < .05$). The hypothesis regarding Conversation was also confirmed since the experienced and experimental therapists did not differ significantly but each scored significantly lower ($p < .01$) than the placebo group. The largest unanticipated differences were obtained for Seeking Personal Information where the experienced therapists were significantly higher than both the experimental and placebo therapists ($p < .01$) although the latter groups were not significantly different. It may further be noted that these differences represented considerable variation between the overall percentages for the group (25.97 per cent for the experienced therapists and 1.04 and 1.54 per cent for the therapists in the experimental and placebo conditions respectively). Of the remaining categories in which significant differences were obtained, it may be noted that the therapists in

Table 25

Process Variables: Summary of Analyses of Variance and Comparisons Between Means

			Duncan's Multiple-Range Test					
			Experienced vs. Experimental		Experienced vs. Placebo		Experimental vs. Placebo	
Variable	F[1]	p	p		p		p	
Reflection	21.24	< .001	< .05	(E > ET)	< .01	(ET > p)	< .01	(E > P)
Conversation	18.21	< .001	NS		< .01	(ET < p)	< .01	(E < P)
Personal Info.	56.52	< .001	< .01	(E < ET)	< .01	(ET > p)	NS	
Directing	9.68	< .001	< .05	(E < ET)	NS		< .01	(E < P)
Positive Comments	19.26	< .001	< .01	(E < ET)	NS		< .01	(E < P)
Negative Comments	4.54	< .05	< .05	(E < ET)	NS		< .05	(E < P)
Miscellaneous	3.76	< .05	< .05	(E > ET)	NS		NS	
Total Verbalizations	48.22	< .001	< .01	(E > ET)	NS		< .01	(E < P)

[1] $\underline{df} = 2.34$

the experimental condition conformed better to the nondirective role than the experienced therapists. The experimental group provided significantly fewer Directing and Orienting Responses and fewer Positive and Negative Comments than the experienced group. The therapists in the experimental condition also gave fewer of these responses than therapists in the placebo groups were not significantly different.

In summary, these findings indicated that the therapists in the experimental condition showed the highest degree of conformity to the nondirective role in terms of verbal behaviors anticipated for persons trained in this approach to play therapy. The students in the placebo group also appeared to conform to the friendly role in that nearly one half of their verbalizations was categorized as conversation with the Miscellaneous and Directing and Orienting Responses accounting for the next highest percentages of their verbal behavior. In a word, when they were not chatting about this and that, they tended to be cooperating, answering the child's questions and providing help. They also tended to provide considerable structure in terms of making suggestions about what to do and how to do it. Many of their Directing and Orienting responses appeared to be a sort of adult helpfulness toward the child rather than a real restrictiveness. In contrast, the experienced therapists did not conform to the nondirective role in several respects. This was especially evident in terms of Seeking Personal Information. As this category was defined for coding it represented the asking of questions designed to elicit information about the child's thoughts, feelings, activities, and interpersonal relationships. As these were used by the experienced therapist, they tended to represent attempts to understand the dynamics of the child's functioning and generally suggested a purposeful approach to having the child recognize his problems and to lead him to ways of handling them by seeing relationships which the therapist pursued through her questions.

Student Measures

The three pretraining measures of students' attitudes and adjustment--Incomplete Sentences Blank (ISB), Michigan Picture Story Test (MPST), and Minnesota Teacher Attitude Inventory (MTAI)--were used to assess the comparability of the subjects assigned to the experimental, placebo, and control conditions. The posttherapy scores for the MPST and the MTAI provided the basis for testing the hypothesis that evidence of positive or constructive attitudes toward children is significantly greater for the students in the experimental condition than those in the placebo or control conditions. In evaluating the differences between the scores for subjects in the three conditions on the posttest, analysis of covariance was used. For each of the variables, the pretraining score on that measure served as the covariate.

The means and standard deviations for the ISB, the MPST, and the MTAI for the three conditions are shown in Table 26. Comparisons of the pretraining scores for each variable in terms of a one-way analysis of variance indicated that the groups were very similar since none of the F values approached significance (see Table 26).

The results of the analyses of covariance used in investigating differences between the conditions on the posttraining measures are shown in Table 27. The results of these analyses for the MPST variables of Focus, Child Scale, and Adult Scale indicated that none of the comparisons was significant. Inspection of the means for the three variables corroborated the fact that none of the ratings showed any evidence of discriminating among the groups and, in addition, that indications of change between the pretraining and posttherapy measures were minimal. In contrast, the analysis for the MTAI revealed a significant difference for treatments ($F = 7.15$, $p < .005$). Inspection of the means for the three groups indicated that the difference reflected the fact that the experimental therapists scored higher than the other two groups on the posttest.

The measures obtained from students in the experimental, placebo, and control conditions were also examined in terms of test-retest reliability and relationship of these measures to the measures of outcome for the child. The MTAI provided the best evidence of adequate reliability with a Pearson product-moment correlation (r) of .85 ($p < .001$) between the pretraining and post-therapy measures. The correlations for the before and after scores for the MPST were lower but were significant (Focus = .31, $p = .05$; Child Scale = .58, $p < .001$; Adult Scale = .61, $p < .001$).

The correlations between the pretest measures for the student therapists and the measures of outcome in terms of change are reported in Table 28. These correlations were of interest in terms of pretraining characteristics which might be related to the students' effectiveness with patients. The obtained rs were generally low and none was significant. With respect to children's scores on Incomplete Sentences, lower scores on the posttherapy measure indicated relatively greater adjustment (or less conflict) than higher scores. Therefore, the obtained negative correlations suggested that good adjustment in the therapist was positively related to improvement in the child. The findings for the MTAI were similar in indicating that positive attitudes toward children were positively related to constructive changes during therapy. The correlations between students' scores on the MPST and the measures of outcome were not impressive. However, the pattern of positive and negative correlations for the change scores for Target Complaints suggested that as the student scored high on Focus (see the child as the hero) and high on the Child Scale, the relationships with outcome were negative. However, as the student scored high on the Adult Scale (indicative of a positive and understanding approach toward the child) the correlation was positive.

Table 26

Descrptive Statistics and F Values for Incomplete Sentences (ISB), Minnesota Teacher Attitude Inventory (MTAI), and Michigan Picture Story Test (MPST)

		Condition						
		Experimental (N = 14)		Placebo (N = 12)		Control (N = 14)		F (Pretest)
		Pre	Post	Pre	Post	Pre	Post	
ISB	M	118.07		127.58		128.07		1.63
	SD	15.70		18.10		13.43		
MTAI	M	58.00	63.07	54.75	53.16	53.36	52.86	< 1.0
	SD	20.33	15.94	31.54	29.07	18.54	17.59	
MPST Focus	M	24.50	26.36	24.00	24.08	23.21	24.43	< 1.0
	SD	3.70	2.87	2.55	3.40	2.70	2.80	
Child	M	22.00	22.79	21.33	21.58	17.21	18.36	< 1.0
	SD	5.32	4.02	4.02	3.66	3.49	5.04	
Adult	M	23.36	22.36	21.33	20.75	20.36	21.00	< 1.0
	SD	3.15	3.81	3.17	3.06	1.91	1.73	

Table 27

Summary of Analyses of Covariance for the Michigan Picture Scores and the Minnesota Teacher Attitude Inventory

		Michigan Pictures						MTAI	
		Focus		Child		Adult			
Source	df	MS	F	MS	F	MS	F	MS	F
Total	38								
Error	36	9.36		15.72		6.49		108.19	
Treatments	2	15.84	1.69	13.74	< 1.0	2.40	< 1.0	773.11	7.15*

*p < .005

Table 28

Intercorrelations Among Student Pretests and Measures of Outcome for Child and Combined Scores of Mothers and Fathers

Measure	Student Measure		Michigan Pictures		
	ISB	MTAI	Focus	Child	Adult
Semantic Differential Actual Diff. (N = 22)	-.25	.22	.04	.03	.37
Target Comp (N = 25)	-.29	.02	-.16	-.10	.23
ISB (Child) (N = 25)	-.11	.05	-.06	-.05	.01

Discussion

The present study was designed to provide evidence relevant to three major areas of interest: (1) the effectiveness of students majoring in education in providing nondirective play therapy for moderately disturbed boys; (2) the extent to which brief training in the techniques of play therapy suggested that the student therapists performed satisfactorily during the play interviews; and (3) beneficial effects for the participating students in terms of attitude change.

The effectiveness of students in the experimental condition (those trained in nondirective play therapy) was evaluated by comparing the measures of outcome for their child patients on the outcome measures obtained by three additional groups (i.e., experienced therapists, friendly students (placebo condition), and a no-treatment control. The inclusion of the placebo condition provided an opportunity to investigate the extent to which students who are simply friendly produce positive changes in their patients. This aspect of the research seemed especially important since none of the studies of the effectiveness of nonprofessional persons in mental health work has provided a comparison of this type. Consequently, it has been difficult to ascertain whether training in a particular therapeutic approach contributed to the effectiveness of the lay therapists or whether the same results might have been obtained if a similar group with no training had provided attention for the patients.

It should be noted that the placebo group was not a true "no-training" group. However, the training for the students in this condition was designed to provide a minimum of instruction in the techniques of nondirective play therapy and to encourage the students to do what they probably would have done without instruction. The alternative of having a group with *no* training seemed impractical for several reasons. First, it would have created the *possibility* that the untrained group would realize that they had not been trained and might believe that they had little chance of helping their patients. This possibility seemed especially likely in the present study since the two student groups were conducting their play interviews during the same period. Second, <u>some</u> training or orientation to the Guidance Center and its policies appeared important in terms of maintaining certain standards (e.g., confidentiality, responsibility to patients). Finally, a complete absence of training for the placebo group would probably have handicapped these students in ways that were not relevant to the central issue of comparing students trained in nondirective techniques with those who were simply friendly. That is, groups with no training or orientation would have been less familiar with the playrooms and the play materials, would not have had the opportunity to "play" with normal boys, and would not have become at least somewhat accustomed to being observed. Thus, for the present study, it was felt that a complete absence of training might create several differences between the student groups which could confound the results. It may also be noted that the trainers believed it was quite possible that students who were simply friendly to the patients might be beneficial since most of the patients did appear to need a friend.

The hypothesis that evidence of improvement in the patients ranged from most to least for children in the experienced therapist, experimental, placebo, and no-treatment control conditions was partially supported. The hypothesis was quite consistently confirmed in terms of the ordering of the means for the outcome measures obtained from their parents, teachers, and the children themselves in the experimental, placebo, and control conditions. The evidence for the experienced therapists was more variable with the experienced and the experimental groups being very similar on the measure of Target Complaints as reported by the parents. However, there was consistently less evidence of improvement for the experimental group in terms of teachers' ratings of changes on Target Complaints and for the scores of both parents and teachers on the Semantic Differential. Evidence of improvement based on the Incomplete Sentences obtained from the children was minimal but was consistent with the trends noted above; children in the experimental and placebo conditions showed slightly greater decreases in conflict in the posttherapy period than those in the experienced therapist and control conditions.

In terms of the significance of the differences between the groups as assessed by Target Complaints, the combined scores for parents and the scores obtained from fathers indicated that the mean differences between the groups were significant for both the experienced therapist and the experimental groups in contrast to the control group. Similar findings were obtained for the Semantic Differential in terms of both parents' perception of change in their child. In this instance, only the differences for the experimentalgroup indicated that children in this condition had improved significantly between the pretherapy and the posttherapy measures. None of the measures obtained from teachers or from the children provided evidence of significant changes indicative of improvement.

The evidence based on the parent measures is encouraging in terms of the possibility that college students with only brief training can contribute to the patients' improvement. In comparison to the students in the placebo condition the evidence suggests that training in nondirective psychotherapy did contribute to the effectiveness of the therapists. Although the mean change scores for Target Complaints did not indicate significant differences between patients in the placebo and the experimental condition or between those in the placebo and control conditions, the consistency with which the outcome for the placebo group was intermediate between the experimental and control groups suggests that the friendly approach may have contributed something more than no treatment but less than nondirective play therapy. Whether this effect, if indeed it exists, should be attributed to the fact that the children did benefit slightly from the attention provided in this condition or whether it was a placebo effect (associated with the expectation of improvement through treatment) cannot be ascertained.

While the findings for the briefly trained therapists in the experimental condition were encouraging, the relative lack of superiority for the more experienced therapists raised a number of questions. In asking why the experienced therapists did not succeed as well as anticipated, several factors must be considered. As the study was

designed, the major independent variable was amount of training and experience in nondirective play therapy. During the course of the study (and as evidenced by the ratings of the process variables during therapy), it became apparent that the experienced therapists were not conforming to the nondirective role. That is, they tended to be more dynamically oriented and to work intensively with the child in trying to alleviate his problems. This difference between the groups was clearly demonstrated in the significantly higher frequency or proportion of times the experienced therapists sought personal information from the child in contrast to the negligible amount of this behavior which characterized the experimental therapists. The present findings suggest that this more dynamic therapeutic approach to the child and his problems was less satisfactory than the nondirective approach (even as executed by students with brief training) in terms of outcome following 12 interviews. It is possible that the approach which was characteristic of the experienced therapists may be more successful over a longer period of time--i.e., the child was more anxious, etc. at the time of the posttherapy assessment but would show greater improvement later. In effect, this argument depends on the notion that the patient is likely to get worse before he gets better. Whether this possibility would be supported if outcome were evaluated following a longer period of therapy cannot be ascertained from the present study. It is also possible that patients seen by briefly-trained therapists would improve more during the longer period.

Another factor which may have affected the results for the experienced and experimental groups was the age of the therapists. It has been suggested in various studies involving lay personnel that college students tend to be highly motivated and enthusiastic and may be successful because they are young. Although it is not entirely clear what youth in itself contributes, it may be associated with being more attractive, more enthusiastic, and more optimistic than their experienced counterparts. It might also be supposed that these college students who were closer in age to their patients and who were still involved with the problems of school found it easier to establish rapport with their patients. While it would be desirable to control this variable, it seems rather unlikely that it was responsible for the obtained differences in outcome for the experimental group because children seen by the students in the placebo condition should have showed results comparable to those obtained for the students in the experimental condition.

A final possibility in terms of the training and experience of the experienced therapists also warrants consideration. It should be noted that while this group was consistently more experienced in therapy and had received more training than the undergraduates, there was considerable variability in terms of experience (i.e., advanced graduate students in psychiatric social work and clinical psychology to those who had their degrees and a number of years of experience in working with children). However, examination of the data in terms of those who had the most experience in contrast to those who had the least did not suggest that this was a contributing factor in terms of patient outcome for the experienced therapists. The results for the two subgroups appeared to be very similar as were the ratings of their performance in the final interview.

In considering the findings for outcome, the results suggest that students with only 12 hours of training in nondirective play therapy can make a significant contribution to children's adjustment as it is reported by their parents. It should be recognized, however, that the evidences of improvement did not mean that the children should be thought of as being "cured" or even that the majority should be considered as having no further need for therapy. As the study was conceived (re-evaluation after 12 interviews) it seemed likely that this relatively brief period of therapy might be insufficient even when treatment was provided by the most experienced of therapists. Consequently, parents were offered the option of having the child continue in therapy if this seemed advisable to both the staff of the Guidance Center and the parents. On this basis, 10 children in the experienced therapist condition continued while 1 was judged to be sufficiently improved to discontinue treatment. Of the children in the experimental condition, 2 were considered improved by both parents and staff, 6 continued treatment, and 6 parents rejected the offer of further treatment although the staff felt it would be desirable. For the placebo condition, 3 children were considered improved, 4 continued treatment, and 4 rejected the recommendation for further treatment. In addition, 1 left the city so that continuance in treatment could not be ascertained. It is interesting that a larger proportion of the parents whose children had been in the experimental and placebo conditions rejected the staff's recommendation for further treatment. While it was somewhat difficult to ascertain the parents' true motivation for this decision, four of the prents stated that they believed that the child no longer needed treatment. Four other parents rejected treatment because they were unwilling to participate in the Guidance Center's program for the parents of children in treatment. Since the parents' participation had been eliminated during the period of the project, it is possible that the parents who later rejected treatment on this basis would not have participated in this research if they had been involved from the start.

Another possible reason for the relative lack of interest in continued treatment for children in the experimental and placebo conditions may have been related to the staff's familiarity with the child and his problems. The experienced therapists, as noted previously, tended to work very intensively with their patients and their reports provided considerable information on each child's problems as well as impressions about his progress. In contrast, the student therapists (regardless of condition) tended to elicit relatively little information about the child's problems and provided few ideas about progress. Thus, the staff who interviewed the parents and made recommendations about continued treatment often mentioned that they felt less certain about their recommendation for children seen by the student therapists. Finally, more of the experienced therapists conducted their own post-therapy interviews with the parents and could provide recommendations based on their experience with the child. It should be noted in this context that the measures of outcome were obtained prior to the interview and, with a few exceptions, by someone other than the therapist.

The second area of interest was the extent to which brief training in nondirective play therapy enabled the student to provide the conditions appropriate to this approach. Two types of evidence, the ratings of the final interview and the process ratings for interviews 1, 4, 8, and 12, were considered in the investigation of therapist performance in the final interview, (e.g., success in drawing out affect, success in using patient's cues, beginning and end of interview) indicated that the experienced therapists were rated significantly higher on all variables than the therapists in the placebo and experimental conditions except for one variable--Respect for Patient. The differences between the ratings for the two student groups were not significant for any of the variables or for the composite of the ratings. These ratings suggested that the experienced therapists were performing at higher levels in terms of the variables under consideration and presumably were doing a somewhat better job. The fact that the ratings for the experienced therapists were generally quite low and indicated that this group was only Passable or Satisfactory raises the question of whether the experienced therapists were performing as well as might be hoped even though they were significantly higher than the student therapists (who often obtained mean ratings suggesting they were quite poor). That the relatively low ratings for the experienced therapists could not be attributed to therapists with the least training and experience was noted previously -- the means for the combined ratings for the more and less experienced therapists were identical.

The lack of significant differences between the ratings for the students in the experimental and placebo conditions also indicated that training in nondirective play therapy did not contribute to the performance of the former group, at least in the estimation of the rater. While their performance may have appeared much the same, it is quite possible that the ratings of the final interview suffered from a problem similar to that noted with respect to the therapists' approach to treatment. Specifically, the rater was simply told to rate the records according to her standards and criteria for performance without specifying that the interviews should be rated in terms of how well the therapist was performing as a nondirective play therapist. Since the rater was a consultant at the Guidance Center and provides supervision to students and staff, it seems reasonable that her criteria for performance were relevant to the more dynamically oriented approach which was reported earlier for the experienced therapists. Thus it seems likely that the only conclusion which can be reached from these ratings is that the students performed less well than the experienced group in terms of certain criteria, but that these criteria may not be particularly relevant in evaluating the nondirective approach.

Finally, it is apparent that the therapists who were performing better in terms of the ratings of the final interview were not achieving greater success with their patients than the student therapists. This is further confirmed by the fact that the correlations between the composite scores for the final interview showed very low correlations with the measures of outcome.

The second measure of performance during therapy utilized the process ratings and appeared to be more relevant in answering the question of how well the students in the experimental condition conformed to the nondirective role. Of the six variables for which directional hypotheses were formulated, the scores for the experimental group were consistently different from those for the placebo group. These significant differences indicated that the experimental group was performing in ways considered appropriate for nondirective play therapy, i.e., higher levels of Reflection and Clarification and lower levels of Conversation, Directing and Orienting, and Positive and Negative Comments. While these findings have emphasized the extent to which the experimental group conformed to expectations, it may be noted that the findings also indicated that the placebo group was following instructions and being friendly. The finding that the students in the placebo condition seldom engaged in Reflection and Clarification is consonant with the findings of Linden and Stollak (1969) and Stover (1966) in indicating that students who were left to "figure out" appropriate therapist behavior and mothers who were untrained performed at significantly lower levels on similar variables. In addition, the comparisons of the experimental and experienced therapist groups revealed that the students showed a significantly greater proportion of responses categorized as Reflection and Clarification than the experienced therapists. The experimental group also scored significantly lower than the experienced therapists in the categories representing behavior which was inappropriate to the nondirective approach (i.e., Seeking Personal Information, Directing and Orienting, and Positive and Negative Comments). The obtained differences between the experienced therapists and the experimental therapists are probably indicative of the fact that the experienced group was not conforming to the nondirective approach and does not necessarily indicate that the performance of the experimental therapists would have surpassed that of therapists who were experienced and actually applying the techniques of nondirective play therapy.

Finally, it may be noted that the proportion of the experimental group's verbalizations which were devoted to Conversation showed a consistent increase from the first to the twelfth interviews and, as might be expected, there was a corresponding decrease in Reflection and Clarification. This may indicate that the lessons learned during brief training may gradually be forgotten over a period of three months and that a refresher course might be advisable if the therapists were to continue. Some evidence of a similar trend was also noted for the experienced therapists. Although it is difficult to make comparisons between the experimental and experienced therapist groups because of their somewhat different orientations, the similar findings for the two groups may suggest that even for more experienced therapists the increasing familiarity with the patient creates a temptation to be more conversational.

In concluding, the present findings provide a certain optimism for the possibility of training students in a brief time (8 sessions, 12 hours) to perform in ways that are considered appropriate for nondirective play therapy. Although continuing instruction in the techniques of nondirective play therapy may be beneficial (and indeed

necessary) for long-term maintenance of this role, it may be noted that the present levels were obtained with very little continuing supervision and no particular attempts to provide further instruction in the nondirective role. Finally, the differences in outcome for the groups characterized by differences in the extent to which they conformed to the nondirective approach suggested that adherence to the principles of nondirective therapy is associated with therapist effectiveness, at least within the limits of 12 interviews.

The final area of interest was concerned with the possibility that students who are trained in nondirective play therapy may benefit from the training and/or their experience in the play interviews. Of the two measures investigated in this context, the hypothesized increase in positive attitudes toward children was supported by the data based on the Minnesota Teacher Attitude Inventory but not by that for the Michigan Picture Test. Since the Michigan Picture measure was developed for the present study and there is no information on the validity of this approach, it is possible that the scores were not measuring what it was hoped they would measure. It is also possible that the students simply did not change in the hypothesized ways. The fact that test-retest reliability for the Adult and Child Scales was reasonably satisfactory only indicated that the scales were measuring something with reasonable consistency.

In addition to the major areas of interest, some attention was given to different approaches to measuring children's adjustment and particularly to the application of these measures in the assessment of therapeutic outcome. Investigations of intrajudge and interjudge reliability for the parents and teachers was consistently significant and fairly high for both the Actual and Ideal Scores. In addition, the agreement between mothers and fathers on the posttherapy measure of their children was fairly high (r = .58) although the pretest correlation was lower (r = .32). The reason for this is not clear since both measures were obtained from the parents independently. In contrast to the correlations for the parents, the mother-teacher and the father-teacher correlations for the Semantic Differential were consistently low and nonsignificant. Although it might be anticipated that the teachers' ratings would show less relationship with the mothers' and fathers' rating than the parents' ratings did with each other, the present findings suggest that the ratings, even for the parents, are not providing the same information on the child.

For Target Complaints, the posttherapy rating of change obviated the possibility of assessing the test-retest reliability. However, the correlations between the parent ratings of change indicated considerable agreement (r = .71) while the correlations between the parents' and teachers' ratings were again quite low. The pretherapy rating of severity of the complaints obtained from the parents was also quite low (r = .25).

For the child measure, Incomplete Sentences, the test-retest reliability was also fairly low (r = .35) although the correlation was significant.

The investigation of the relationships between the measures of outcome indicated that the correlations between Actual Change on the Semantic Differential and the change scores for Target Complaints were moderate and significant for both fathers and teachers and approached significance for mothers. These suggested that there was at least some relationship between the same respondent's reporting of change on the two measures. With a single exception, the correlations between change on Sentence Completion and the adult respondents' scores for Actual Change on the Semantic Differential and the change scores for Target Complaints were negligible. Although there were no additional criteria against which to evaluate the validity of the measures of outcome, the findings were somewhat encouraging for the Total Actual scores on the Semantic Differential but quite poor for Sentence Completion. The impression of the raters in scoring the Incomplete Sentences Blank for the child subjects was that the Rotter and Rafferty (1950) approach may be considerably less appropriate for fairly young children than it is for college students. This may be attributable, in part, to the absence of a scoring manual appropriate for children's responses. However, in spite of this problem, the inter-rater agreement was quite satisfactory for the children's protocols. Perhaps more inherently a problem for the younger children is the fact that they frequently gave rather stereotyped responses which are scored at a neutral level. They also gave completions that suggested the child had certain common associations which he presented whether they applied to him at the moment or not (e.g., the stem "I feel..." was very frequently completed by "sick.").

The factor analysis of the Semantic Differential provided a first step in investigating particular patterns of behavior in terms of factor scores. The fact that very similar factors were obtained for mothers, fathers, and teachers--a finding that partially replicated the work of Becker (1960) -- provided encouragement for the possibility that this approach might be useful in the assessment of problem areas and possibly in the assessment of outcome. However, the initial investigation of change in terms of the factor scores for the pre- and posttherapy measures was generally unproductive. The relatively small number of subjects created certain questions with respect to the factor analysis and particularly with respect to the method used in obtaining the factor scores. Further research utilizing the factor analytic approach is recommended.

In concluding, several considerations about the use of the present findings and recommendations for further research appear appropriate. First, the present study provided evidence which indicated that education majors may be quite effective in providng nondirective play therapy. The findings clearly suggested that this approach is worthy of further investigation as well as the possibility that other groups with brief training can work constructively with emotionally disturbed children. It seems reasonable to suggest that the initiation of an actual program utilizing lay personnel with training similar to that received by students in the experimental condition could be of considerable benefit to moderately disturbed children. Needless to say, a program of this type should be carefully supervised and professional

workers should be available for consultation about special problems.

The fact that a number of questions about the effectiveness of nonprofessionals in mental health roles and their training remain unanswered further suggests the importance of additional research in this area. As was pointed out previously, the confounding of therapeutic approach and training in the present investigation suggests a need for comparing lay personnel with brief training in nondirective play therapy with experienced therapists using the same approach. In addition, research involving longer periods of therapy should be instituted to provide information on the extent to which lay (and professional) personnel could help children if they were given more time. It was felt that the 12 interview limit utilized in this research was somewhat too short to evaluate what might have been accomplished in more sessions. Specifically, it appeared that it took several interviews for the children (and perhaps the student therapists) to feel comfortable in the play situation. The therapists' notes frequently indicated that interesting and relevant material was presented by the child in about the seventh or eighth interview. However, concerns about terminating the relationship appeared to provide interference in the subsequent interviews so that, in effect, there were relatively few interviews in which the therapist and child might work together in a truly therapeutic relationship. This is, of course, conjecture and evidence of greater effectiveness through longer treatment can only be obtained by further investigating this variable.

A second consideration in prolonging therapy and particularly in having the same lay personnel see a succession of patients is the extent to which they would remain effective. It seems possible that the initial enthusiasm about learning something new and providing help for a disturbed child may diminish considerably over time. In addition, there is evidence which suggests that programs which initially seemed very helpful later failed to produce change. This may be due not only to the waning enthusiasms of those most directly involved (the therapist) but to the lower motivation and interest of other personnel involved in the project. Since no study has investigated the use of the same lay personnel over an extended period of time, evidence for their continued usefulness in mental health roles suggests that this variable should be investigated. Even with brief training, the possibility that new groups must be trained at frequent intervals would suggest that lay personnel are less promising than it has been hoped in meeting the manpower shortage in mental health.

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Appendix A

_ _ _ _ _ _ _ _ _ _ Name_____

C#_____ Date_____

INCOMPLETE SENTENCES

Please complete the following sentences as rapidly as possible. Try to express your real feelings and opinions.

1. I like

2. The happiest time

3. I want to know

4. Back home

5. I regret

6. At bedtime

7. Men

8. The best

9. What annoys me

10. People

11. A mother

12. I feel

13. My greatest fear

14. In school

15. I can't

16. Sports

17. When I was a child

18. My nerves

19. Other people

20. I suffer

21. I failed

22. Reading

23. My mind

24. The future

25. I need

26. Marriage

27. I am best when

28. Sometimes

29. What pains me

30. I hate

31. This place

32. I am very

33. The only trouble

34. I wish

35. My father

36. I secretly

37. I

38. Dancing

39. My greatest worry is

40. Most women

Michigan Picture Story Test: Description of Pictures

No.		Order for Presentation
3.	Schoolroom, teacher, pupils, boy standing.	2
4B.	Man and boy--man seated and boy standing beside him.	4
4G.	Woman and girl with doll seated on couch.	1
10B.	Man behind desk, boy standing.	5
10G.	Man and young girl, both seated. Girl reading.	3
11B.	Woman, boy, and man standing in doorway. Man appears to be in uniform. Man and boy seen from the back.	6
11G.	Girl sitting at school desk surrounded by empty desks.	7

Scoring for Michigan Picture Story Test

A. Focus of story in terms of central character or "hero."

Rating:

1. Adult focus. Emphasizes adult's actions and point of view; child(ren) as basis for episode but very little or no attention to child in terms of action, personality, or outcome.

2. Predominantly adult focus but some attention to child(ren). Emphasis is likely to be on thoughts, feelings, and actions of adult but a few comments are devoted to the child as a person.

3. Adult-child focus about equal. Story-teller devotes about one-half of attention to each by describing first one and then the other and not seeming to make either the main character.

4. Predominantly child focus but some attention to adult. (See 2 above)

5. Child focus. Emphasizes child. (See 1 above)

B. Child Scale. Child's feelings, thoughts, and motives. Rating indicates how "tuned in," insightful, or empathetic the adult (or story-teller) is. If adult and story-teller differ, score the higher level.

Rating:

1. Description of situation or problem--what is happening in terms of action (e.g., child listening to story, reciting in class, stealing) with no attention to his thoughts, feelings, or motives.

2. Mention of a single, obvious thought, affect, or need for the child (e.g., child looking worried, child looking bored, child feeling unhappy). Similarly, needs are noted at simple level, as child wanting help. Reasons for actions not explained or may be noted as occurring by accident.

3. Mention of two or three feelings, thoughts, etc. at fairly obvious level--more descriptive than insightful or dynamic. Includes general or stereotyped statements about motivation and children's development (e.g., as teacher does "right" thing, children will grow emotionally, socially, etc.).

4. More attention to feelings, thoughts, and needs of the child with evidence of concern about "why" of behavior but fairly stereotyped. Statements may be similar to level 3 in terms of the notion that if the adult acts a certain way the child will respond in a particular way (e.g., as adult disciplines child without understanding or trying to get child's reasons, child will be depressed, comply out of fear, etc.). However, these relationships tend to be presented as insights for the particular characters so that, for the story-teller at least, they have a certain freshness. The story-teller has some "feel" for the child but, in contrast to level 5, this is not elaborated--the story is a vignette.

5. Emphasis on feelings, etc. in such a way that story provides a picture of the child as a real and fairly unique person.

C. Adult Scale. Adult's approach toward child in terms of a negative-positive continuum to be judged on the basis of what the adult does and feels, the child's perceptions, and the story-teller's comments. When the adult disciplines the child, the judgment of whether the approach is "good" or "bad" should be based on the story and not on the rater's ideas of what would have been appropriate.

Rating:

1. Adult is clearly and actively negative or hostile (e.g., rejecting, disgusted, fed up). Aside from direct statements to this effect, the adult's actions may show him as unwilling to help the child or be so ineffectual that he cannot. The parent or adult who is seen as damaging the child through his thoughtlessness and/or severe discipline also receives this rating.

2. Picture of adult is somewhat negative (he is saddened, disappointed, etc.) in child and/or his actions fail to show awareness of child's problem. At this level the emphasis suggests inadequacy on the part of the adult rather than open hostility or rejection--his negativeness is more inadvertent. Inadequacy is likely to be reflected in the child's negative reactions or his failure to respond to the "good" intentions of the adult.

3. The adult's feelings toward child are unspecified in story or the adult is pictured as simply doing his duty (e.g., lectures, teaches, disciplines to correct behavior). He acts in a routine way (child does not know his lesson and adult gives him a talking to). Also, when adult is upset or angry for a real reason (child did do something upsetting) and the adult acts as above.

4. Adult shows some indications of positive attitudes toward child and/or understanding of his problem, but these are not elaborated (e.g., adult is fair, just, interested, not put out). In general, the good intentions of the adult should be seen as related to positive outcomes for the child (in contrast to level 2) but need not if the child is clearly in the wrong or would not respond positively no matter what the adult did. If the adult in story fits level 2 but story-teller uses episode to point out inadequacy of adult's approach, score at this level.

5. Adult is distinctly positive and shows a high level of awareness of child's needs and problems and/or his approach shows thought and concern in planning for child. The adult of level 4 is more passive in his acceptance and understanding; the adult at this level is more active (or at least there is more evidence suggesting he is "tuned in" and doing his best in a constructive way).

Appendix B

Target Complaints

Instructions for interviewer:

Pretest

"We are interested in learning more about what problems or difficulties parents who come to our clinic want help with. What problem or difficulties does your son have that you would like our help with? . . . Anything else? . . . Anything else?"

If problems are inappropriate for treatment setting, ask: "But which problem or complaints would you like to have (Name) helped with in treatment?"

If symptoms or complaints seem interrelated, work with parent to see if agreement on combining them is possible.

Note responses verbatim in blank form. When all complaints have been elicited, write each on the top of the sheet with the 13-pt. scale for rating severity. Give sheets to parent and explain rating system.

Posttest

Have each complaint recorded on rating sheet with the 7-pt. scale for change.

"You probably remember that I asked you about the problems or difficulties you would like to have (Name) helped with during treatment. Now I am interested in learning how these problems are at this time and whether there are any new ones. First, here are the problems you mentioned." Ask parent to rate any changes that have occurred from the time of the first interview. Do not reveal how parent checked problem the first time (leave sheets in file to avoid debate).

Finally, inquire if any new problems have arisen since the pretest and record them. Note "none" is that is the case.

— — — — — — — — —

TARGET COMPLAINTS

Child's Name_____
Respondent: Mother____ Father____
Date_____
Pretest_____ Posttest_____
Interviewer_____

Pretest: Record problems verbatim and obtain ratings of severity; staple together.

Posttest: Record any new problems and obtain ratings of severity and change on original problems; staple together.

TTS PROJECT: TEACHER

Child's Name_____

Date_____

Please describe briefly the problem areas which you would like to see this child helped with during psychotherapy at the Loyola Guidance Center. Such aspects of his behavior as achievement in school, concentration, cooperativeness, relationships with classmates, or anything else you think important would be appropriate. Since we recognize that few children are perfect, we are especially interested in areas in which his performance is not in line with that of most children of his age or others at his level of IQ.

Problem 1:

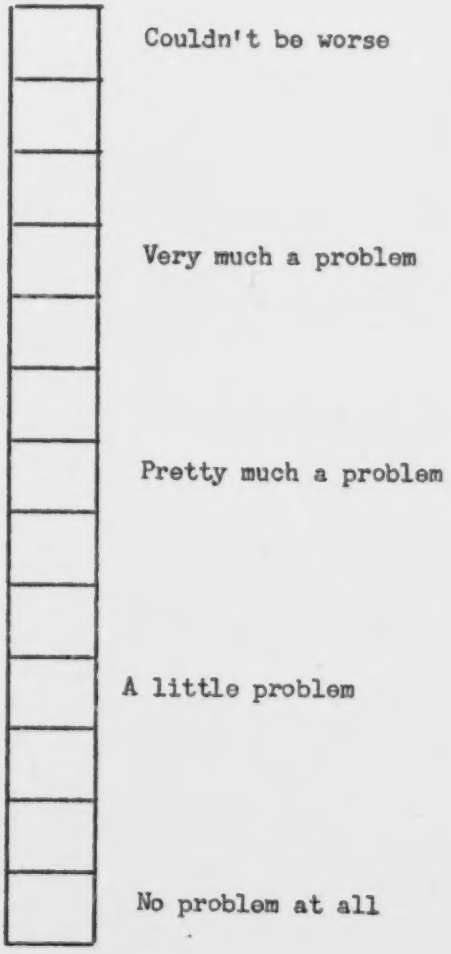
Problem 2:

Problem 3:

Other problems or comments:

Child's Name_____
Respondent: Mother___ Father ___

At present, how much of a problem (how serious or troublesome) do you find this?



Child's Name_____

Respondent: Mother _____ Father_____

Code:___ ___ ___ ___ ___ ___ ___ ___

Problem:

Has this problem changed since the first time we talked about it several months ago? Please check the box which best describes the change.

Much Worse	Somewhat Worse	Slightly Worse	No Change	Slightly Better	Somewhat Better	Much Better

Child's Name_____

Respondent: Mother _____ Father_____

Code:___ ___ ___ ___ ___ ___ ___ ___

Problem:

Has this problem changed since the first time we talked about it several months ago? Please check the box which best describes the change.

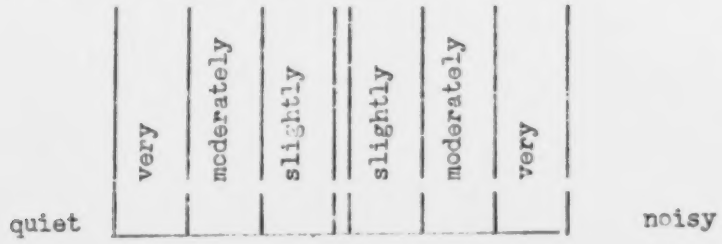
Much Worse	Somewhat Worse	Slightly Worse	No Change	Slightly Better	Somewhat Better	Much Better

Have you noted any <u>new</u> problems in terms of this child's behavior?

Child's Name_____
Respondent: Mother___Father___Teacher_____
Date_____
Pretest_____ Posttest_____

We would like to have a general picture of _____.

For example, if you are given the choice:

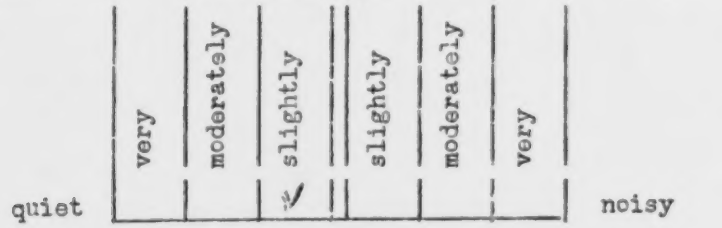


1. First ask yourself if he is basically a quiet or basically a noisy child.

2. If he is basically a quiet child, you will use the half of the line which is closer to the word "quiet."

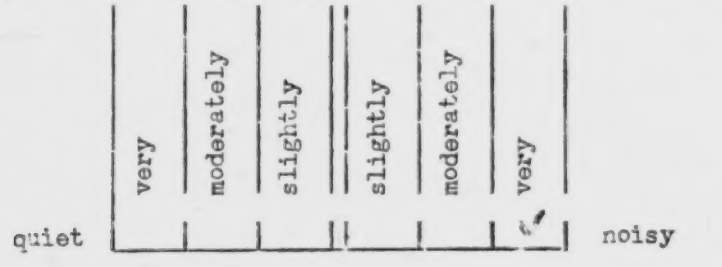
   Then ask yourself: is he very quiet, moderately quiet, or slightly quiet and place a check mark on the quiet half of the line under the word which tells how quiet he is.

   for example, if he is slightly quiet, it will look like this:



3. If he is basically a noisy child, put a check mark on the noisy half of the line and show if he is slightly noisy, moderately noisy, or very noisy.

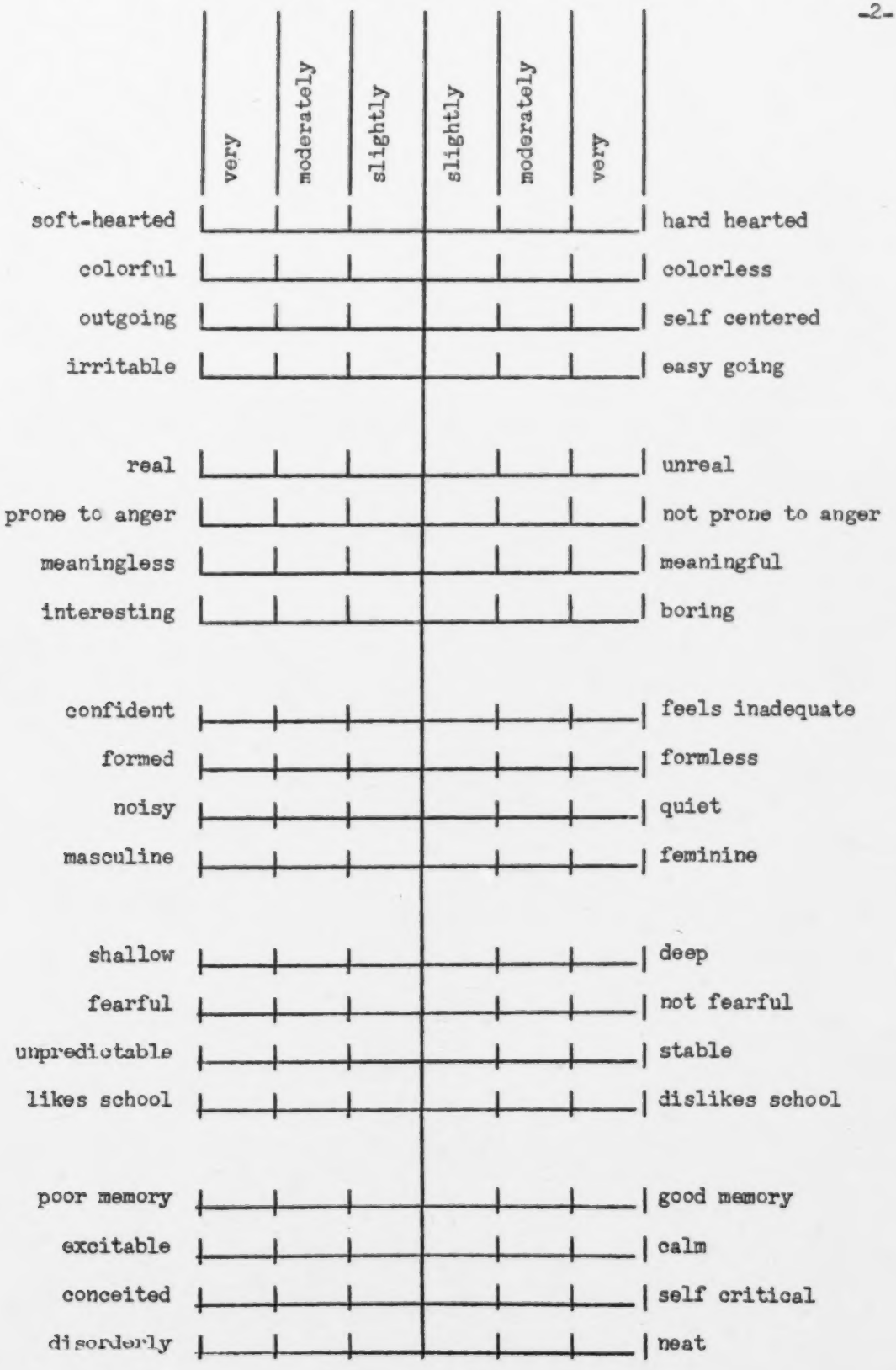
   For example, if he is very noisy, the line will look like this:

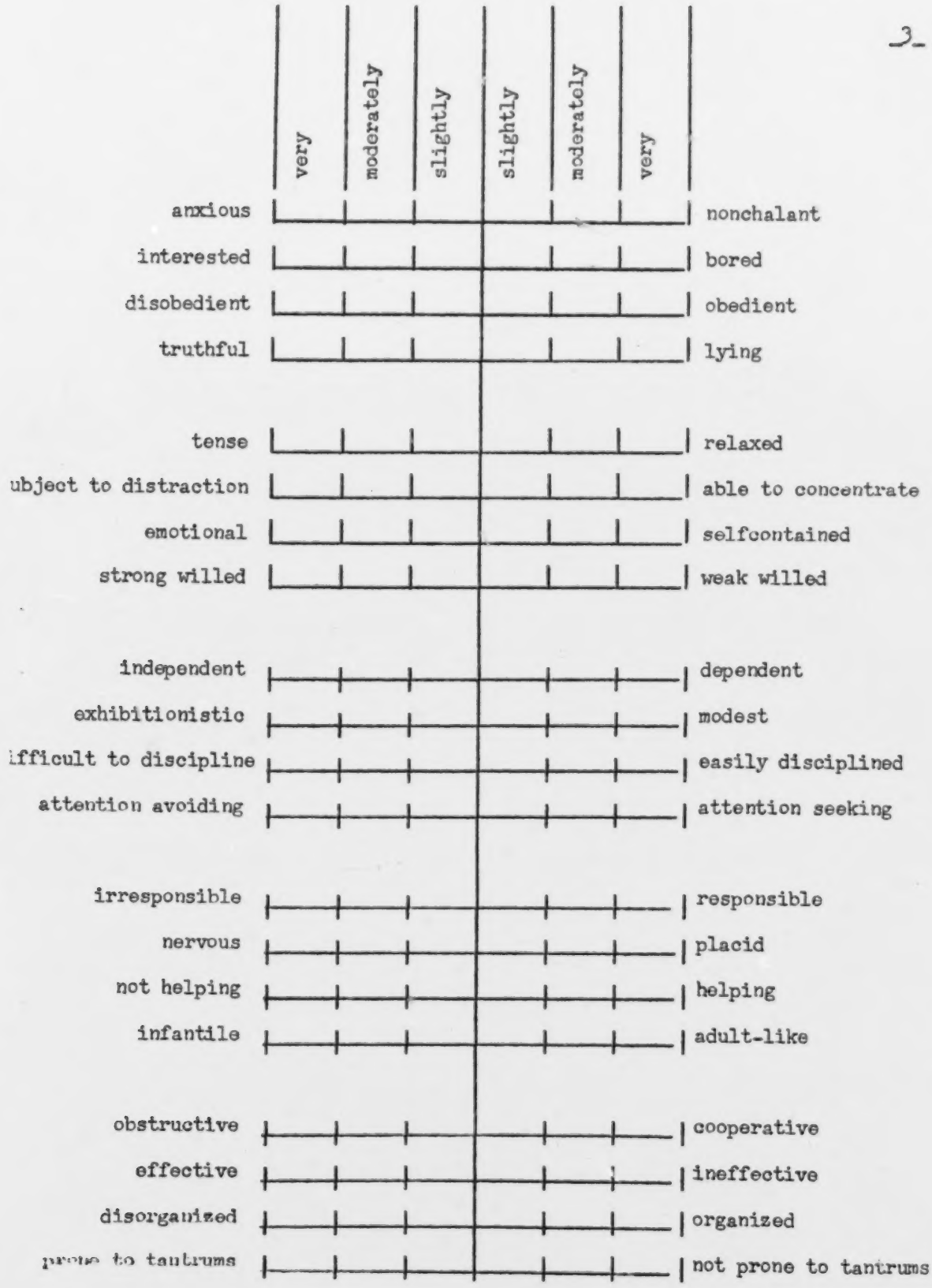


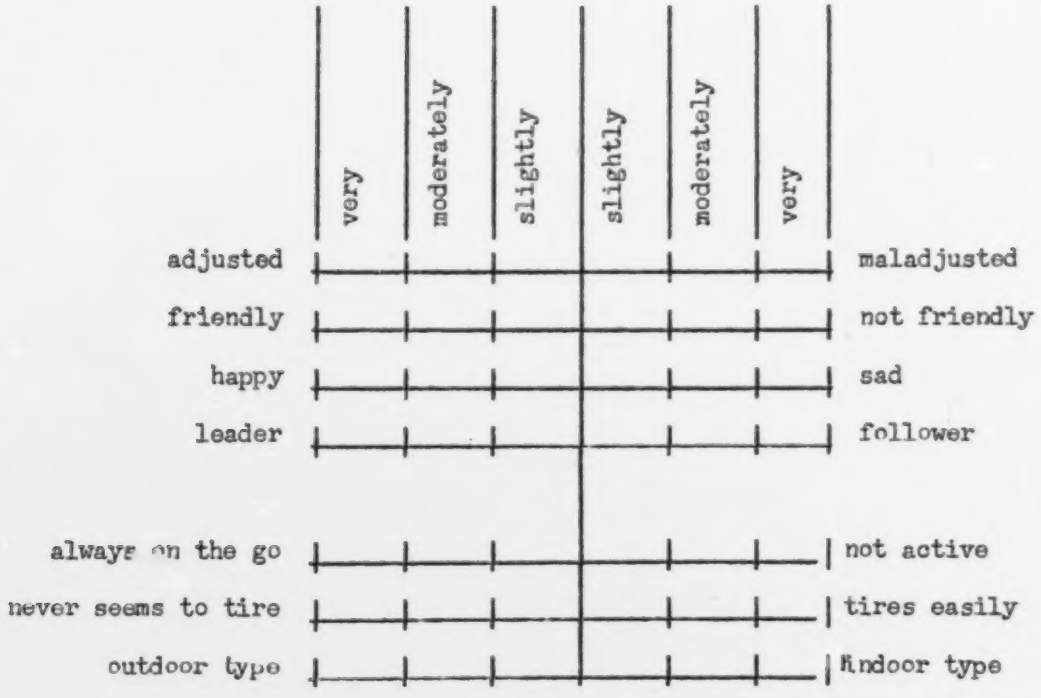
Please do this for <u>each</u> of the following lines.

	very	moderately	slightly	slightly	moderately	very	
Active							inactive
extroverted							introverted
sociable							unsociable
cruel							kind
conscienceless							conscientious
dominant							submissive
happy							depressed
dull minded							intelligent
loving							not loving
demanding							not demanding
trusting							distrusting
tough							sensitive
jealous							not jealous
quick							slow
curious							uninquiring
optimistic							pessimistic
warm							cold
impatient							patient
responsive							aloof
adventurous							timid

BE CERTAIN YOU HAVE PUT ONE CHECK MARK ON EACH LINE


very
moderately
slightly
slightly
moderately
very
soft-hearted
hard hearted
colorful
colorless
outgoing
self centered
irritable
easy going
real
unreal
prone to anger
not prone to anger
meaningless
meaningful
interesting
boring
confident
feels inadequate
formed
formless
noisy
quiet
masculine
feminine
shallow
deep
fearful
not fearful
unpredictable
stable
likes school
dislikes school
poor memory
good memory
excitable
calm
conceited
self critical
disorderly
neat

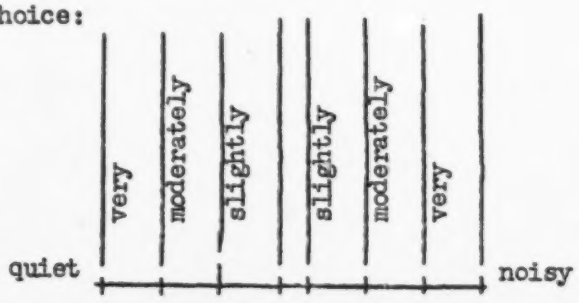

very
moderately
slightly
slightly
moderately
very
anxious
nonchalant
interested
bored
disobedient
obedient
truthful
lying
tense
relaxed
ubject to distraction
able to concentrate
emotional
selfcontained
strong willed
weak willed
independent
dependent
exhibitionistic
modest
ifficult to discipline
easily disciplined
attention avoiding
attention seeking
irresponsible
responsible
nervous
placid
not helping
helping
infantile
adult-like
obstructive
cooperative
effective
ineffective
disorganized
organized
prone to tantrums
not prone to tantrums


very
moderately
slightly
slightly
moderately
very
adjusted
maladjusted
friendly
not friendly
happy
sad
leader
follower
always on the go
not active
never seems to tire
tires easily
outdoor type
indoor type

Now we would like to know your feelings about how you <u>would like</u> to have

_____ behave.

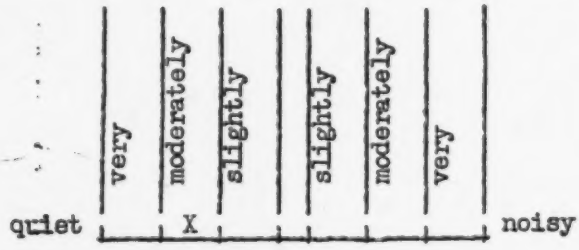
For example, given the choice:



1. First ask yourself if you <u>want</u> him to be basically <u>quiet</u> or basically <u>noisy</u>

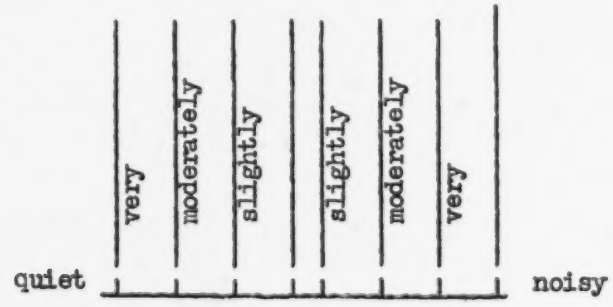
2. If you want him to be <u>basically quiet</u>, put an X on the quiet half of the line under the word which tells how quiet you want him to be.

   For example, if you want him to be <u>moderately quiet</u>, the line would look like this:



3. If you want him to be <u>basically noisy</u>, put an X on the noisy half of the line and show whether you want him to be <u>slightly</u> noisy, <u>moderately</u> noisy, or <u>very</u> noisy.

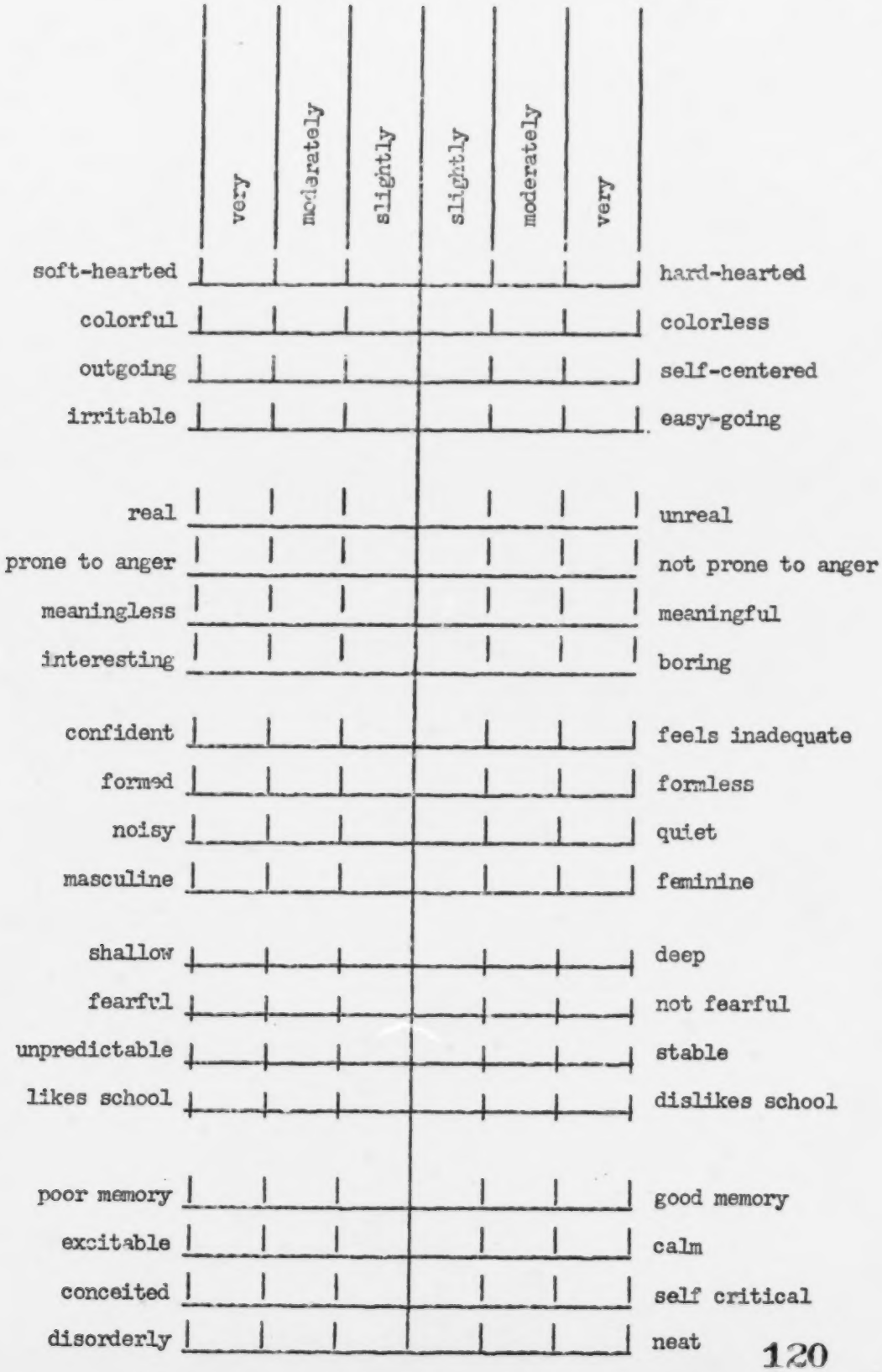
   For example, if you want him to be <u>slightly noisy</u>, the line would look like this:

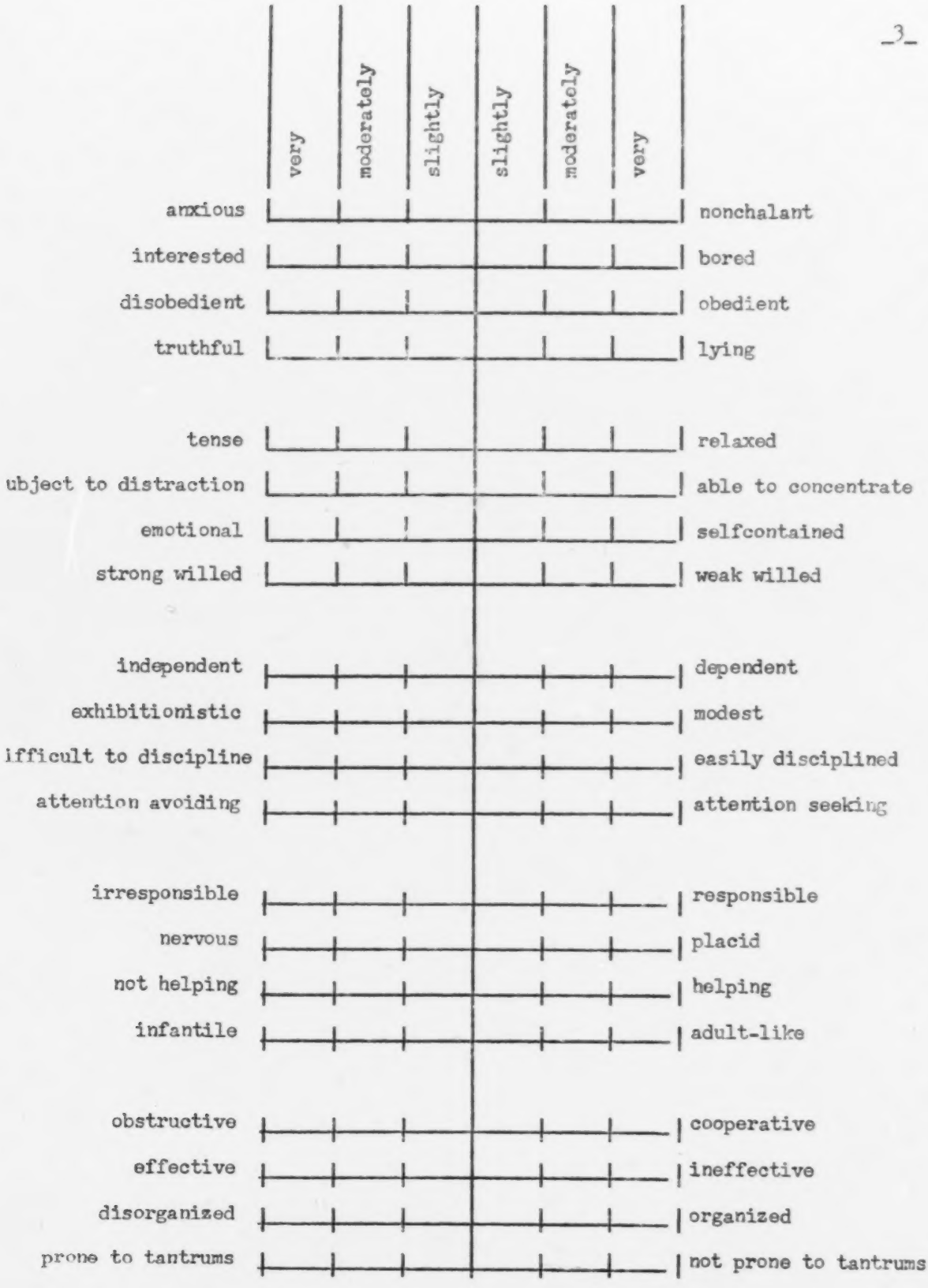


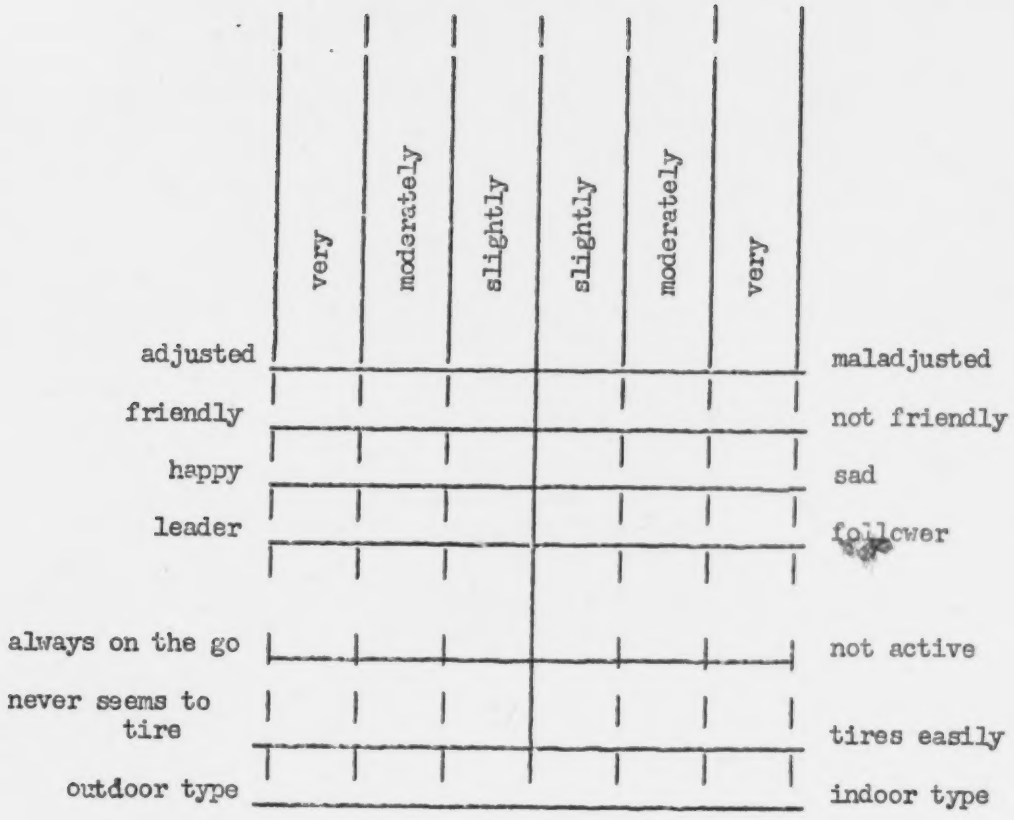
Please do this for each of the following lines.

	very	moderately	slightly	slightly	moderately	very	
Active							inactive
extroverted							introverted
sociable							unsociable
cruel							kind
conscienceless							conscientious
dominant							submissive
happy							depressed
dull minded							intelligent
loving							not loving
demanding							not demanding
trusting							distrusting
tough							sensitive
jealous							not jealous
quick							slow
curious							uninquiring
optimistic							pessimistic
warm							cold
impatient							patient
responsive							aloof
adventurous							timid

BE CERTAIN YOU HAVE PUT ONE CHECK MARK ON EACH LINE


very
moderately
slightly
slightly
moderately
very
soft-hearted
hard-hearted
colorful
colorless
outgoing
self-centered
irritable
easy-going
real
unreal
prone to anger
not prone to anger
meaningless
meaningful
interesting
boring
confident
feels inadequate
formed
formless
noisy
quiet
masculine
feminine
shallow
deep
fearful
not fearful
unpredictable
stable
likes school
dislikes school
poor memory
good memory
excitable
calm
conceited
self critical
disorderly
neat


very
moderately
slightly
slightly
moderately
very
anxious
nonchalant
interested
bored
disobedient
obedient
truthful
lying
tense
relaxed
ubject to distraction
able to concentrate
emotional
selfcontained
strong willed
weak willed
independent
dependent
exhibitionistic
modest
ifficult to discipline
easily disciplined
attention avoiding
attention seeking
irresponsible
responsible
nervous
placid
not helping
helping
infantile
adult-like
obstructive
cooperative
effective
ineffective
disorganized
organized
prone to tantrums
not prone to tantrums


very
moderately
slightly
slightly
moderately
very
adjusted
maladjusted
friendly
not friendly
happy
sad
leader
follower
always on the go
not active
never seems to tire
tires easily
outdoor type
indoor type

Appendix C

Rating of Final Interview

Name of Rater: _____

Code: ____ ____ ____ ____ ____

	Excellent	Good	Satisfactory	Passable	Poor
1. Global impression of interview					
2. Respect for the patient					
3. Interest in the patient					
4. Understanding of the patient					
5. Success in drawing out affect					
6. Beginning of interview					
7. End of interview					
8. Professional attitude					
9. Skill in using patient's cues					

	Very easy	Easy	Medium	Difficult	Very difficult
Patient's accessibility to therapy (i.e., an easy or a difficult patient)					

Remarks:

Process Ratings for Play Interviews

Instructions for Coding Therapists' Verbal Interactions

Definition of Interaction Unit

A unit of interaction is defined as each verbalization (phrase, comment, grunt, or exclamation) which is preceded by an action or comment of the interacting child. The response unit consists of everything the adult says between two child responses.

In scoring the unit, each sentence (or group of sentences expressing the same thought) is coded for only one category. However, if there are additional ideas expressed, each may be coded for the category to which it belongs. For example: "That's very good. Why don't you draw a house next?" is coded for Positive Comments and for Orienting and Directing. The same category may be used twice in a single unit if the two comments represent different thoughts or are separated by a pause. For example: "Now you are going to fill in the black. (Pause) You really enjoy coloring." are each scored for Reflection of Content and Feeling."

Categories Used in Coding

The following 12 categories are used in coding the therapists' responses plus a thirteenth category, Transcription Difficulty. This category is used whenever the therapist's (T's) comment cannot be heard or where so few words can be heard that it is impossible to assign the comment to a particular category. For the purposes of a final score, four categories are combined as Miscellaneous Responses (Unclassified Responses; Simple Recognition; Seeking Impersonal Information, and Solicited Cooperation, Information, and Help). In addition, the three reflective categories are combined for Reflection and Clarification (Reflection and Clarification of Content and Feeling; Reflective Leads; and Reflective Structuring). The remaining categories are considered separately.

1. Unclassified Responses. Brief responses in which the intent of the therapist's verbalization is not clear; T requests repetition due to failure to hear or repeats a phrase as a question, apparently because she was not sure she heard it; and other brief comments and exclamations.

Examples: What? Pardon me. Thank you. Houses? What time is it? Whoops! Oh-oh!

2. Simple Recognition. Brief verbalizations indicating that T is following the conversation and is being an attentive listener.

Examples: Um-hmm. Yes. I see. Really! It did! Wow!

3. Seeking Impersonal Information. The T's questions about ongoing activities in the play interview are categorized here. These questions most commonly are aimed at obtaining information about the game in progress or how things work. The questions often suggest that T is less familiar with the game than the child (C) or wishes to let him establish the rules and is trying to find out about them.

Examples: What is the score? Whose turn is it? Does this man go here? What happens if you hit the red? May I move here? Does this count? That's an out when it goes there?

4. Solicited Cooperation, Information, and Help. Responses included in this category are generally brief and suggest that T is complying with C's request. The simple giving of information about time, etc. is categorized here but longer explanations involving the structure of the play interview or attempts to get C to make his own decision or choice are classified with Reflective Structuring. If T goes beyond the simple request in providing information and begins to sound as if she is instructing or lecturing C, the verbalization is coded with Directing and Orienting Responses.

Examples: It is 4 o'clock (after C has asked time).
You have 15 minutes more (after C has asked about time remaining).
O.K. (after C has suggested way to do something).
Yes, I'll hold it for you.
Yes, I'd like to play checkers.
Um-hmm (after C asked if she got something done).
Yes, there is an observer today.

5. Conversation. This category is characterized by T's friendly interest in C, especially in terms of his activities and interpersonal relationships outside of the play interview. However, casual comments about ongoing play activities are included here. The questions T asks may be similar to those categorized as Seeking Personal Information but can generally be differentiated from them in terms of context and subsequent questions. That is, the questions that qualify as Conversation appear to be devoid of any purpose except a rather casual but friendly interest in C. In addition, the affective tone is generally positive and T is likely to talk about her own reactions and experiences. These personal comments are included here if they do not suggest that she is trying to influence C's thoughts or activities, reflect his feelings, or be instructive. It also includes bantering and kidding if these responses are clearly

friendly and do not represent a subtle way of belittling C. Finally, Conversation is also indicated by T's failure to follow through when C does express his feelings or his concern about some problem.

Since Conversation is best distinguished in context, several long examples are provided.

Examples: T and C have been playing a game and talking about school.

T. What kind of machines do you learn in that?
C. Oh, a saw and a drill.
T. That's pretty good. I wouldn't know how to use one of those.
C. It's easy. I learned how when I was little.
T. Do just the boys take that or do the girls, too?
C. The girls do, too.
T. Oh, yeah (as Simple Recognition).
C. We have gym, too.
T. Do you have a man teacher for that? A lady?
C. Um-hmm. (aff.) Today I was mad at myself because in the gym they had poles running across the top. You know, like in a bracket they go across.
T. Yeah (Simple Recognition).
C. They were across and we had to climb up it and I don't know how to do it. And the other guys, it looks like a lot of fun but I can't climb the poles.
T. Can the other guys do it?
C. Most of them. Some of them can't. I'm just new with the school and they have been practicing.
T. It probably would be fun once you get the hang of it. What other kinds of stuff do you do in gym? Play basketball and that kind of stuff?

C has been telling T about using marker pens on the bedsheets.

C. On the sheet. All over the sheet. It's green and red and black--you know--with all those peace things on the--you know--peace, peace, peace.
T. (Laughs) The sheets on the bed?
C. Yeah. And we got all those things there and, uh . . .
T. How old is your brother?
C. He's 13.
T. You're kidding!

C. And there's one end of the bed where I was sitting--I mean there's red all around it!
T. Oh, gee, that's something I haven't tried yet.
C. Boy, when my mother finds out though. She asked me today, "Have you finally made your bed without me asking?"--you know.
T. Does your brother come home before you do?
C. No, he's always stopping over at a friend's house or something. But when I come home from school, I always go straight home, get changed, and then I go out.
T. I always like to change my clothes first, too.
C. Yeah. I don't like school clothes.
T. You're not the only one. It's really getting bad, 'cause we're not supposed to wear slacks to school, but about two days per week I just decide, I'm not going to wear a skirt today.

C.has been telling T about catching bats.

T. Oh, gads! Did you catch any of them?
C. Yeah. We caught three. One was black. Boy, black bats are hard to see around here. The other was a brown one. It was about that long.
T. I have these visions of bats being those huge vampire bats or something.
C. Yeah. Ahhgg!
T. Yeah--I've been to Wisconsin. My sister and I were walking one time and her hair is sort of out here--
C. Yeah?
T. And all of a sudden something flew into her hair . . . (T relates episode at some length.)

6. Seeking Personal Information. This includes Stover's (1966) category of "Directive Leads." As she noted, these are used when the adult wishes to have the child elaborate on something that they have been discussing or to "lead the child in the direction of, or directly to, an area of discussion. A Directive Lead is designed to stimulate thought, focus attention, cause the child to discover contradictory ideas or behavior within himself, see obscure motivations, or discover relationships new to him (p. 100)." Included here are all questions designed to obtain specific information about the child's personal life and relationships with others as well as his thoughts and feelings. The adult frequently appears "pushy" in trying to obtain the information which the child may be somewhat reluctant to give. As with Conversation, the context is important and the coding of a particular question may be clarified by considering the subsequent questions. For example: T. "Did your father bring

you today? C. "Yes." T. "Oh, I thought I saw him in the waiting room." is coded as Conversation. However, if the T's second response was: "How did you feel about that?", it would be coded as Seeking Personal Information.

Questions in this category are frequently interspersed with comments coded as Reflection and Clarification of Content and Feeling, i.e., T discovers how C feels through direct questioning and then makes a reflective statement.

As with Conversation, a series of questions and responses is helpful in presenting this category.

Examples: C has been telling T how his father hit him for not washing a glass and he had to leave school because of a headache the next day.

T. And what happened then?
C. I have to wash it.
T. Did that hurt you pretty bad when your Dad hit you?
C. Yah.
T. Where did he hit you?
C. On the side of the door.
T. I mean, did he hit your arm or your head or what?
C. My head.
T. He hit your head and you fell into the door?
C. Naw--he pushed me into it.
T. Well, what happened after that?
C. And then I got to go to bed.
T. This happened at night?
C. Yeah.
T. I see. Did your head hurt at night when you went to bed?
C. Not that much.
T. Who else was there when that happened? (T then pursues who was there and how they felt about this. P reports that his mother was in bed and that his brother and sister saw it and were scared--they cry when their father hits them but he (C) does not.)
C. Sometimes he makes us scared and sometimes he doesn't.
T. What do you mean, makes us?
C. Like if somebody's being hit at our house and my brother and sister--they get scared. 'Cause they think they might, uh, be getting hit next.

T. Were your brother and sister scared the other night when it happened?
C. Yeah.
T. Did they cry?
C. Nope.
T. Did you cry?
C. Nope. I hardly ever cry. My brother said I'm as hard as a rock.
T. What do you think he means by that? (T then pursues crying, and reflects on how he must have felt like crying).

The T inquires about C's ideas about the Guidance Center.

T. Do you have any ideas about what kind of a place this is?
C. Well, no.
T. How about a guess.
C. Clinic?
T. And what's a clinic?
C. Well, it's--um--it's like a hospital but--um--they have people that pay, you know, real cheap.
T. You say a hospital--a hospital you go to when there's something wrong with you?
C. Well, yeah.
T. Somebody told you that? That there might be something wrong with you. That's why you're coming here?
C. Yeah.
T. Well, this is a place--(T explains about Clinic).

7. Directing and Orienting Responses. All verbalizations included here tend to take the initiative away from C through subtle or very direct manipulations or to restrict his actions. This category applies to C's activities both in the play situation and outside. T may give unsolicited help, information, suggestions, or instruction. In these approaches, T tends to act like a teacher or an authoritative adult. T may also engage in unsolicited participation in that she not only enters into the activity but tries to have C do things her way rather than following his lead. This includes structuring games, selecting pieces for C to use in construction, and establishing the rules for games. T may also make comments or ask questions which carry the implication that C should be doing something differently. Finally, T may restrict C's activities and suggest limits that are not the established limits for the play interviews (see Reflective Structuring).

Examples: What about playing this game?
Now see if you can get all of these in (referring to sticks in Ker-Plunk game)...They have to go straight because if they are at an angle you can't get so many in.
Put that over here so it will be out of the way.
Let's use two of these instead of one.
Aren't you going to have any windows in your house?
Be careful not to go off the paper with those paints (not a necessary limit).
I wouldn't do that.
No, don't turn off the light.
Here, give me some of those and I'll help you.

8. Positive Evaluation. This category consists of T's responses which indicate a positive evaluation of the child in terms of praise, positive comments, and approval as well as a positive orientation toward the child in terms of encouragement, reassurance, and the giving of permission. These comments refer to activity in the play session or outside of the session.

Examples: That is a very nice picture.
I really like you with that tan.
Good play! You are very good at putting those blocks together.
You almost got it--keep trying.
Don't worry if some water goes on the table--we can wipe it up.
Yes, it's okay if you paint.

9. Negative Evaluation. This category includes T's responses indicating or implying criticism, disagreement, sarcasm, noncooperation, and rejection, as well as statements or interpretations which suggest a negative evaluation of C. Comments suggest that T does not accept C as he is or his actions.

Examples: C. My finger is in there.
T. Oh, well, take it out.
C. I can't get my finger out of here.
T. Can't you get your finger out of there?--Poor thing.
You dying? (as C makes sucking noises)
Well, you shouldn't have moved it. (speaking of C's mistake in constructing a building)
Not now--maybe I'll do it later (C has urged T to talk in funny puppet voice).
I'm not talking back to you (in response to C's statement that she is).
You don't listen to me when I talk to you about school.
You're cheating.
You're interrupting me again.

10. Reflection and Clarification on Content and Feelings. The three subcategories comprising this category were based on the coding system used by Moustakes et al. (1956) in which he distinguished eight levels of reflection. In the present study, the first two categories representing simple restatement of verbalizations and activities were combined as were his third and fourth categories. The last four categories of Moustakes et al. represented a variety of attempts to clarify feelings at higher levels and were combined in the present system--an approach which seemed especially warranted since their research indicated that these categories were used quite infrequently.

In using the three categories, no attempt is made to rate the accuracy or sensitivity of T's comment. While this is undoubtedly important, it may be noted that the most frequently used type of reflective comment was simply a restatement of the child's verbalization or activity and, as such, left little room for error. The second subcategory, involving reflection and recognition of feelings suggested by child's verbalizations or activities, tended to rely on fairly obvious expressions of affect and did not appear to subject to gross misinterpretations. The third subcategory, involving attempts to clarify feelings at higher levels, provided the greatest challenge for the therapist but was relatively little used.

(a) Simple Restatement of Verbalizations or Activities. T restates what the child has said without adding or simply notes what C is doing.

Examples: You liked school today (following C's statement that he liked school).
Now you are putting in the windows (as child adds adds windows to structure).

(b) Reflection and Recognition of Feelings Through Verbalizations and Activities. T states the feeling that is implied or suggested in an obvious way. The manner of reflectin the child's feelings and actions suggests acceptance rather than a Positive or Negative Evaluation.

Examples: You seem sort of concerned about what the observer might be writing (as C peeks through one-way mirror and asks what the observer is doing.
You really seem to enjoy painting (as C enthusiastically starts a second finger painting).

It's hard to know what to think when your father doesn't seem to listen to what you are telling him (a propos of C's report of trying to get permission to buy a camera and not being sure whether his father really heard him since he ignored C).

(c) Attempts to Clarify Feelings at Higher Levels. At the simplest level (according to Moustakas et al.) the T provides elaboration beyond the obvious feelings or actions of C. The second level is similar to the first but includes comments on feelings not immediately verbalized or elaborated in motor activity. At the third level, T attempts to clarify feelings by noting spatial or temporal ties. At the fourth level, the T attempts to clarify the child's simple statements or obvious feelings by relating them to the reality of the situation--or the reality as T sees it.

Examples: You want to win the last game of Ker-Plunk (final play session and child has just decided he wants to play one more time).

I think you want to beat me today, don't you? (as they set up checkers and C asks T if she will win today.).

Well, you're still afraid that she might bring you a little bit of bad luck by telling your mom and dad stuff (with reference to C's comments that the observer will bring him bad luck because she's watching him play the game).

You're angry because we're not going to be coming in the morning anymore, I think, and so you just squirt it (C has been squirting a whole tube of paint on paper and not liking the product--almost attacking it).

(He then states he doesn't care and later that he just wanted to miss a little school)

T continues: Um-huh . . . Since you can't miss a little school, you'll mess a little paint. We'll find when we look at your pictures, that when they're like this it was on days that you were sort of upset about something and on the days that you were feeling sort of problem solving, feel like solving problems and stuff, that they are not so messy. (C has been making a mess with finger paints and was obviously angry with what

he has produced. He had asked to see the paintings from the previous sessions which T had saved.)

Maybe it could be like feelings and stuff like that --the kind we talked about last week. You know, when you were writing on the paper things that you didn't feel that you could talk about. (C has been very reluctant to talk about his feelings--probably angry ones).

11. Reflective Leads. The therapist provides general encouragement for the child to talk about himself, his feelings, and his thoughts. In contrast to Seeking Personal Information, the therapist is not "pushy" about pursuing particular topics and lets child take the lead. This category includes tentative interpretations in which the therapist wonders whether some idea might apply.

Examples: But I don't know how you would feel about coming back (This is the final session and T is trying to explore C's feelings about continuing in therapy after this, the research period).
That's what I can't figure out--I can't figure out how you do see it.
So this is going to decide who is going to be the championship basketball player?
What else happened?
Tell me more about it.
How do you want me to act?
What do you want him to say?

12. Reflective Structuring. This response category consists of statements relating to the play session process. It is generally structuring for permissiveness. It may be used to define limits or to explain the responsibilities of T or C. Permissible limits under this category are only the following: Not harming self, not physically hurting or dirtying T, and not damaging the playroom (e.g., not breaking the mirror or lights). Reflective Structuring tends to occur more frequently in the early interviews and toward the end of therapy when T is likely to discuss termination and plans for the posttherapy interview with C and his parents.

Examples: We have 12 times to be together (and other similar information about the interviews).
You have five more minutes.
Explanations about the observer, the microphone, and the tape recorder.
We can't take the mike plug out of the wall.
You can't hit the window.
You can say anything you want to in here.
This is your play session. The important thing is what you want to do.